

# PSYCHIATRY: *Descriptive and Dynamic*

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OXFORD & IBH PUBLISHING CO.  
CALCUTTA NEW DELHI BOMBAY

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SM9

K6

13043

FIRST INDIAN EDITION 1966

Rs 12.00

For Sale in India, Japan, Taiwan, Okinawa, Vietnam, Cambodia, Laos,  
Thailand, Malaysia, Burma, Indonesia, Pakistan, Ceylon,  
Afghanistan, and Hong Kong

This book has been published with the assistance of the Joint  
Indian-American Standard Works Programme

Published by Oxford & IBH Publishing Co 36, Chowringhee Road,  
Calcutta-16 and Printed by Diamond Offset Works Pvt. Ltd , New Delhi-1.

To My Wife, Barbara

## PREFACE

The aim of this book is to describe concisely the various syndromes seen in psychiatric patients and to make these syndromes recognizable to student and physician alike. Rare and obscure conditions have been minimized in favor of detailed discussions of the more frequently seen disorders

The signs and symptoms on which the diagnosis of the various disorders rests are described: this is in keeping with ordinary medical practice in which diagnosis precedes treatment.

Controversy, areas of theoretical discord, and nonmedical speculation have been minimized. The prevailing dynamic concepts are included, as well as a brief review of their origins. Theoretical differences between the founders of the different schools of psychiatry are mentioned.

I sincerely appreciate Mrs. Reba Benschoter's assistance in reading and re-reading, and her help in organizing this material.

I am equally indebted to Mrs. May Granaas for her patience in *retyping my interminable revisions* and to Mrs. Jean Barber, Mrs. Erma Conley, and Mrs. Esther Richards, Librarian, for their assistance.

J. A. S.

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# I

## *HISTORY OF PSYCHIATRY*

### The Ancients

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Benjamin Rush

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Dorothea Lynde Dix

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Emil Kraepelin

Eugen Bleuler

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## *History of Psychiatry*

The history of the treatment of the mentally ill is understandable only in the light of the society in which the patients existed and the medical practice prevalent in a particular era. Unless the level of care for those physically ill at a given time is understood it may erroneously appear that mental patients were singularly maltreated. For instance, if the lack of care and the 42 per cent mortality in the large barracks hospital when Florence Nightingale began her work in 1855 are compared to the efforts to avoid deception and restraint of mental patients reported 19 years earlier at the McLean Hospital in Boston, the mental hospital appears somewhat less foreboding and the treatment seems, if no more adequate, considerably less mortal.

The prescriptions given those with emotional disorders were similar to those given the somatically ill; they too were bled, purged, blistered or given vomits. A major difference in management resulted from the mentally ill's disturbing the group in which he lived. If this disturbance was sufficient, the patient was excluded. With the ancient Greeks this exclusion from society meant confinement in the home of a relative, or several patients might be gathered up and transported to the outskirts of a neighboring town where they would be released under cover of darkness as happened in the colonies in North America.

When mental illness ceased to be divine, those afflicted became instead possessed; this advance in knowledge was hardly a ben-

efit to the patient Perhaps the most detrimental opinion regarding the mentally ill was the conclusion that they were insensitive to pain This added to public acceptance of their physical maltreatment

The concept was also prevalent that the patient's "will" had to be broken Isaac Ray in 1869 made this comment on the previous harsh or abusive treatment of mental patients "I do not refer to chains, or close confinements, though they were common enough, but rather to the principle which underlaid this treatment It was supposed to be the first, fundamental step in management of the insane, to make them feel that they were in the hands of a keeper who required implicit obedience and whose look must be sufficient to put down the slightest show of resistance In one word, their will was to be broken and they were to know no other will but that of their keeper"

Until 1830 in America paupers were remanded to those who would support them for the least cost The individual who made the lowest bid in turn attempted to get whatever work he could, by whatever means, from his charges (This was hardly the beginning of occupational therapy) Those classed as paupers included the mentally ill and the mentally defective as well as the destitute By the middle of the 19th century this system was replaced by poor houses as much for economic as humane reasons

During the first 40 years of the 19th century the rise in medical quackery, encouraged by inadequate licensing laws did much to lower the physician's status with the public This loss of status and the tendency to regard the mentally ill as more a legal than a medical problem encouraged keeping these patients in almshouses and jails throughout the country Perhaps no one individual before or since has done as much to improve the lot of such patients as a school teacher, retired because of ill health Dorothea Lynde Dix

In spite of the misconceptions the treatment of the mentally ill and their occasional release from institutions seems to have been influenced markedly by the society which previously excluded these patients For instance, the following was noted in 1846 Leuret's extraordinary treatment of delusion with the cold douche, at the Salpêtrière a few years since was mainly directed against the dis

position of unmarried women to remain in the hospital after recovery" This presumes that the treatment was not unduly harsh, except for the cold douche, or at least that hospitalization was no less brutal than the existence in the community to which the patients were reluctant to return

The lack of 'intense and completely uncontrolled excitement in the mental hospitals in Europe was attributed by Isaac Ray to a want of food He noted that the greater number of inmates of English hospitals were from the pauper class" This group he distinguishes as follows " a class entirely unknown in the United States—what I mean is with us poverty is a casual condition a temporary misfortune, the result of accident, disease, or mischance, and dies out with its unfortunate subject The British pauper is a sui generis without like or analogue in any other cycle of humanity He is born a pauper, lives a pauper, dies a pauper, and leaves behind him a train of pauper successors "

The contributions to the understanding of mental illness made by the following individuals were outstanding for the era in which they lived.

## THE ANCIENTS

### *Hippocrates (460-370 B C)*

Hippocrates held that the brain was the organ of the mind and that epilepsy was no more sacred than any other illness He added that such a belief was merely confusing divinity with ignorance His opinions on epilepsy and its origin are found in his writings "But such persons as are habituated to the disease know beforehand when they are about to be seized and flee from men—this they do from shame of the affliction and not from fear of the divinity as many suppose" He further contrasts the behavior of the adult so afflicted with that of the child " and little children at first fall down wherever they may happen to be, from inexperience—for being still infants they do not know yet what it is to be ashamed " Finally, as to etiology "Its origin is hereditary like that of other diseases "

Illness was described by Hippocrates as resulting from a disturb-

ance in the four basic humors blood (sanguinary), phlegm (phlegmatic), yellow bile (choleric), and black bile (melancholic) He also took note "physicians are many in title but very few in reality"

### *Asklepiades (c 100 B C)*

This Greek physician came to Rome about 91 B C, he rejected the doctrine of body humors and maintained the physician should be the master of Nature and should heal "safely, rapidly and pleasantly" This goal is not presently without pertinence (c 1959) and should not be abandoned

He recommended humane treatment, well lighted and well ventilated rooms, occupational therapy and exercise to improve memory and attention In addition he used wine and music in treatment, his practice was extensive

### *Galen (c 200 A D)*

Galen was born in Pergamon, a center of culture in the Greek world When he was 33 years of age, he went to Rome and shortly became physician to the emperor His anatomical studies of the brain (based primarily on animal dissection) included descriptions of the dura and pia mater, the corpus callosum, the pineal body, hypophysis cranial nerves and other structures

He believed with Hippocrates in the four humors and attributed insanity to an excess of moisture in the brain He concluded the pituitary was a filter through which impurities accumulating in the brain were discharged by way of the ethmoid into the pharynx His findings were followed for 1500 years

### *Caelius Aurelianus (c 400 A D)*

Believed to have practiced in Rome, Aurelianus recommended the mentally ill be kept in as ideal conditions as possible and that exciting and overly stimulating factors be removed He saw the importance of the attendant in patient management and was much opposed to physical restraint and flogging emphasizing instead the advantages of pleasant distraction He described paralysis epilepsy (which he differentiated from hysterical convulsion), stammering and speech defects

## HOSPITAL REFORMS

Humane treatment of mental patients in hospitals was introduced by Pinel in France in 1792, by Chiargui in Italy in 1789, by Fricke in Germany in 1793, and by Tuke in England in 1796.

### *Pinel*

Pinel, who was physician to the Bicetre Hospital, initiated his reforms during the French revolution. He apparently retained the favor of the Revolutionary Commune since those who did not were only briefly tolerated. Pinel also attempted to classify all disease under five headings in his *Nosographique Philosophique*.\*

### *Esquirol*

Esquirol, who later became Pinel's pupil, was studying for the church when the revolution began and a "tribunal which only thirsted for blood" was in perpetual session in the town of Narbonne where he lived. He succeeded Pinel at the Bicetre Hospital and presented a report on the mental hospitals in France, with recommendations for their improvement, to the central government.

This report, along with his efforts and those of Ferrus, resulted in the passage of a law in 1838 which gave new legal status to mental patients. This law regulated the movement, admission and discharge of the mentally ill and prevented their being transported or housed with criminals. As Esquirol remarked: "... For the first time the law treats mental patients as it does other sick people."

### *Tuke*

The reforms initiated by Tuke resulted in the establishment of the York Retreat for the care of the mentally ill; in 1815 a committee to investigate the "madhouses" in England was appointed. Henderson points out that the manic episodes of George III and

\*Paradoxically, in this era of reason in the treatment of the mentally ill, other social reforms were not so humane. The year after Pinel freed his patients from their chains the worship of God was abolished and the 'Cult of Reason' was substituted in its place. Under the 'Cult of Reason' a revolutionary tribunal was established which permitted juries to convict without being delayed by argument or evidence. Using this system, executions were efficiently, if not justly, carried out at the rate of 300 a month.

the treatment he received while hospitalized increased public awareness of the management of the mentally ill. When the King was hospitalized, he apparently received the routine therapy, which included being knocked down, placed in a straight jacket and blistered.

## AMERICAN

### *Weir Mitchell (1830-1914)*

Mitchell was born in Philadelphia, graduated from Jefferson Medical College, and studied with Claude Bernard in Paris. In 1875 he introduced the "Rest Treatment," also known as the "Weir Mitchell Treatment" for nervous disease. This treatment consisted of prolonged rest, a full diet, and massage. Weir Mitchell was the leading neurologist of his day; he described ascending neuritis, reflex paralysis, causalgia, erythromalgia, and the psychology of amputation. In addition to his medical efforts, he wrote at least two widely read novels.

On the occasion of the 50th anniversary of what is presently the American Psychiatric Association, the membership found Weir Mitchell's address stimulating, if not pleasant. He said: "We neurologists think you have fallen behind us, and this opinion is gaining ground outside of our ranks and is, in part at least, your own fault . . . where . . . are your careful scientific reports? . . . You live alone, uncriticized, unquestioned, out of the healthy conflicts and honest rivalries . . . ."

### *Benjamin Rush (1746-1813)*

Rush was born in Pennsylvania and, took his degree from Edinburgh in 1768. He had been referred to as "the first American psychiatrist." In addition to his medical activities, Dr. Rush was quite active in affairs of his community and country. He was a signer of the Declaration of Independence and was actively opposed to slavery, capital punishment, and alcohol.

\* It is of interest to compare Dr. Mitchell's remarks to those of Dr. Percival Bailey, 62 years later when he delivered the academic lecture at the 112th meeting of this organization: "The task of the psychiatrists, it seems to me, is to get back into the asylums and laboratories which they are so proud to have left behind them, and prove by established criteria that their concepts have scientific validity."

Among his observations was one on treating the alcoholic, showing the beneficial result of "the association of the idea of ardent spirits with a painful or disagreeable impression upon some part of the body"; he accomplished this disagreeable impression by adding tartar emetic to the alcoholic's drink. The patient treated in this manner became so ill he thought himself poisoned, and for the succeeding two years he could bear neither the sight nor smell of whiskey. This procedure does not differ greatly from the present aversion or conditioning treatment.

Medically, he advocated a low diet, heavy purging and bleeding to the point of faintness; during a yellow fever epidemic there was some disagreement regarding the "cures" he claimed for his method of treatment. A pamphleteer named Cobett (whom he later successfully sued) observed that Dr. Rush's cure was "one of those great discoveries which have contributed to the depopulation of the earth."

His "Medical Inquiries and Observations upon the Diseases of the Mind" published in 1812 was the first American text on psychiatry and the only one of American origin for 70 years. He noted the role of heredity, injuries and malformations of the brain, diseases of the body, and drugs in the production of mental illness. He advocated humane treatment, exercise, and hydrotherapy. Dr. Benjamin Rush was perhaps the first to prescribe a tranquilizer, although his tranquilizer was not a drug but a rather uncomfortable restraining chair.

#### *Amariah Brigham (1798-1849)*

In 1844, Brigham founded the "American Journal of Insanity" which later became the "American Journal of Psychiatry." In the beginning, he was the chief contributor and for a time its publication was a drain on his own resources. He was appointed superintendent of the State Lunatic Asylum at Utica in 1842; under his supervision this institution became known as a "training place for Superintendents."

Carlson gives an excellent description of the treatment and practices advocated by this physician, from which the following examples are taken: Brigham opposed bleeding for insanity and



stated that he thought it to be "generally improper and frequently very injurious"; he found opium and ether vapor effective. His ideas about restraint were equally rational: "We never permit anyone to be confined but for a short time," and he adds that it is rare to use restraint other than confining the patient to his room. "We believe that sometimes restraint of this kind is better for patients than to permit them to exhaust and injure themselves."

Brigham's admission procedures are surely worthy of note: "Many are brought to us in chains . . . these are immediately removed and the patient is kindly addressed and assured he is among friends . . ." In 1845 he stated: " . . . we much prefer that a patient should occasionally break a pane of glass or tear some of his clothing than keep him constantly confined." Finally, he warned against undue optimism and "too much *couleur de rose*" in annual hospital reports, which tended to mislead the public.

#### *Dorothea Lynde Dix (1802-1887)*

While teaching a Sunday school class in a Massachusetts jail, Miss Dix learned that the mentally ill, unlike the other prisoners, had no heat in their cells. She subsequently led a movement to provide hospitals and treatment for the mentally ill and to prevent their being held in jails and almshouses.

Miss Dix has been described as the "greatest social reformer in American history"; possessing as she did the zeal to reform and the practicality to accomplish the necessary changes, she contributed to the establishment of no less than thirty mental institutions.

Her efforts were made both here and abroad. She was not always warmly greeted; in Scotland she was described as "the American Invader." However, her appeals led to the establishment of a commission to investigate the mental hospitals in that country.

#### EUROPEAN

##### *Jean Charcot (1825-1893)*

Charcot was a professor in the medical faculty of the University in Paris, first of pathological anatomy and later of nervous and mental diseases; as such he founded the remarkable neurological

clinic at the Salpêtrière Freud lists as one Charcot's major contributions his focusing the interest of physicians on hysteria and dignifying this perplexing illness with his concern

Charcot held that heredity was the originating cause of hysteria therefore it was a form of degeneration and all other causes were only precipitating (*agents provocateurs*) He was able to produce hysterical paralysis during a hypnotic state thereby implicating specific ideas as being productive of hysterical symptoms He described a *grande hystérie* and a *petite hystérie* Freud and Janet were among his pupils

In addition he described lesions in locomotor ataxia as well as gastric crises and joint involvement (Charcot's joint) He made contributions on cerebral localization aphasia military aneurisms and gout To clarify his demonstrations with patients he used a stage and footlights

### *Emil Kraepelin (1856-1926)*

Kraepelin was born in Mecklenburg Germany He was much influenced by Wilhelm Wundt and introduced physiological psychology into psychiatry Kraepelin was an assistant to Flechsig until he was appointed professor at Heidelberg in 1890 and was given a similar appointment at Munich in 1904

In the present dynamically oriented era Kraepelin is frequently referred to as the Father of Descriptive Psychiatry with the same degree of tolerance that is shown for Hippocrates and his four humors It should be noted though that in Europe the teachings of Kraepelin are still in daily use and research continues to be conducted along many of the avenues he pioneered

Adolph Meyer said that it was through Kraepelin that psychiatry advanced from a philosophical discipline toward a natural science and began to develop methods similar to those practiced in clinical medicine Kraepelin's research institute was the first in psychiatry and included laboratories of chemistry pathology serology and psychology When Kraepelin began his efforts workers were floundering helplessly around in a morass of symptoms for which they were unable to find any common denominators

He concluded hebephrenic catatonic paranoid and simple dis

orders were but types of a single disease process—a deteriorating illness, dementia praecox. Kraepelin differentiated from dementia praecox a second group of patients whose illness was inclined to be periodic and who had a more favorable prognosis (not deteriorating) and designated this group as manic-depressive insanity. The elated and depressed episodes were recognized as phases of the same basic disorder.

Kraepelin repeatedly altered his classification as data accumulated, and by 1911 he had retreated somewhat from his earlier position that dementia praecox always ended in deterioration. The stress which Kraepelin placed on "the determination of what happened to the patient through years and decades," and the necessity of basing an interpretation on the "total clinical picture," rather than a symptom, merit re-emphasis today.

In addition to the differentiation of manic-depressive and dementia praecox as forms of mental disease, Braceland pointed out that "he (Kraepelin) carried psychiatry away from symptomatic confusion which barred its advance and provided the first comprehensive and reliable descriptive system psychiatry has known."

#### *Eugen Bleuler (1857-1939)*

After observing mentally ill patients for 12 years at Rheinau in Switzerland, Bleuler concluded that patients diagnosed dementia praecox did not regularly progress to a deteriorated state nor did the illness always have its onset at puberty. He regarded the disorder more as a disorganization (or splitting) of the personality than a "mental enfeeblement" or dementia.

Bleuler wrote regarding his coining a new word for this disease: "It is quite impossible to find a perfect name for a concept which is still developing and changing. I call dementia praecox 'schizophrenia' because (as I hope to demonstrate) the 'splitting' of the different psychic functions is one of its most important characteristics." It is to be noted that he speaks of dementia praecox or the group of schizophrenias.

In 1897 Bleuler was appointed professor of psychiatry at Zurich and director of the Burgholtzli Clinic. He and his assistant, Carl Jung, were both interested in Freud's teachings and their applica-

tion in psychotic patients Bleuler appreciated the importance of the psychological findings and of psychotherapy in schizophrenia. In addition to coining the name schizophrenia he described ambivalence and autistic thinking he also delineated the syntonetic and schizoid personality types

*Pierre Janet (1859-1947)*

Janet was a pupil of Charcot. He introduced the term psychasthenia for those psychoneurotic types presently classified as obsessive-compulsive and phobic reactions. Janet held that the synthesis of the personality depended on a psychic tension, a lowering of this tension resulted in different elements being dissociated or split off from the stream of consciousness.

In hysteria the lowering of the psychic tension was localized to a particular or complicated function or in any event one difficult for the patient. This was in contrast to psychasthenia in which a general lowering occurred. The etiology of hysteria thus became a depression of mental function with a consequent retraction and dissociation due to the lowering of mental energy. The dissociation involved a poorly developed function which happened to be fully active at a moment of great emotion.

A memory or thought competent to arouse strong and lasting emotions can play the part of a fixed idea and may originate hysterical symptoms. Janet noted that some fixed ideas were particularly frequent in certain patients and that the nature of such ideas was in accord with the age, the education and the social position of the patient.

He further stated that a memory was made morbid by dissociation since it was isolated without control and without counterpoise. The symptoms disappeared when such a dissociated memory again became part of the personality. But if these memories were forced on a consciousness which would not tolerate them they would be again dissociated and the process would have to be repeated.

He held that anxiety arises in connection with inadequacy of action of any kind and not solely as an outcome of sexual inadequacies and added that in many cases sexual disturbances are

not the cause of the nervous disorder but are its consequence and its expression." Many people were said to fall ill "because their life is commonplace, dull and monotonous, because they have no hope, no ambition, no aim; because no one is interested in them . . ."

He did not share the generally held disillusionment over treatment by suggestion and remarked: "Today, I run the risk of making people laugh at me by saying that hypnotism counts for something after all. The contempt and the laughter leave my withers unwrung." Success in psychotherapy was said to depend on a number of unknown and personal factors (stature, beard, or tone of voice) and the most insignificant and fallacious part of a therapeutic system were the theories offered in explanation. Janet was less than enthusiastic over analytical efforts "to explain in one breath history, morality, religion, and fits of hysterics."

In discussing psychotherapy he noted: "Every specialist vaunts his own method, declares that it is original, and wants to use it as a cure-all. One specialist will apply moralizing treatment to everyone, another will hypnotize all who come to consult him, another will subject all his patients to rest, and another will psychoanalyze all and sundry. What would we think of a doctor who proposed to administer digitalis to all his patients . . . ?"

# *SCHOOLS OF PSYCHIATRY*

Carl G Jung

Personality as Described by Jung

Parts of the Personality

Attitudes

The External Attitude (Persona)

The Internal Attitude (The Anima or Animus)

Individuation

The Introvert

The Extrovert

Differences between Jung's Analytical Psychology

Psychoanalysis and Adler's Individual Psychology

Alfred Adler

Differences between Individual Psychology and Psychoanalysis

Summary

Sandor Ferenczi

Harry Stack Sullivan

On Interviewing

Karen Horney

Differences with Freud

Existential Analysis

Summary

## *Schools of Psychiatry*

### CARL G JUNG (1875- )

Jung, a Swiss psychiatrist, trained with Eugen Bleuler at the Burgholtzli Clinic at Zurich. He was familiar with Freud's early publications, and did not share the prevalent skepticism, but pointed out the only way Freud's theories could be refuted was by an individual using psychoanalytical methods. Subsequently Jung along with Bleuler applied psychoanalytical principles in an attempt at understanding dementia praecox. In 1906 Jung published his classic monograph *The Psychology of Dementia Praecox*. This volume develops with unusual completeness the evolution of the concepts expressed.

In the preface to this monograph on dementia praecox Jung expressed his reservations regarding Freudian theory, particularly infantile sexual trauma and the placing of sexuality so preponderantly in the foreground. However, Jung was well received by Freud and in 1909 Jung accompanied him on his trip to America but apparently some friction developed between them on the journey. During the succeeding four years the discord increased and in 1913 Jung withdrew from the psychoanalytical movement. He founded his own school and termed his method *Analytical Psychology*.

Jung developed the word association test which consisted of 100 words. These were read to the patient and his associations to each stimulus word were noted. An individual might show a delay in



responding, fail to respond, or be unable to produce the previous association when the stimulus word is repeated. Other types of reactions include repeating the stimulus word, displaying unusual behavior while replying, or considering each word a personal question.

The term "complex" was coined by Jung to describe a group of associated ideas having a strong affective tone. He concluded that words which produced an unusual response were "complex indicators" and that by grouping such indicators at the completion of the test, an impression of the patient's problem could be gained.

### *Personality as Described by Jung*

#### PARTS OF THE PERSONALITY

The *ego* is defined as the psychological expression of the firmly associated union of all general bodily sensations. It is the core of consciousness and in the normal person the ego-complex is the highest psychic force.

The *unconscious* is made up of two parts: a personal unconscious which ends at the earliest memories of infancy, and a collective unconscious which constitutes the pre-infantile period, that is, the residues of ancestral life.

The relationship of the conscious to the unconscious is compensatory, but the superior function is always the expression of the conscious personality. The unconscious, being complementary to the outer character, 'contains all those general qualities the conscious attitude lacks.'

He whose prevailing external attitude is intellectual is sentimental within and vice versa, a similar relationship holds for the individual's sexual character. Man, for instance, is not in all things wholly masculine but has also certain feminine traits. The more manly his outer attitude, the more will his womanly traits be effaced. Similarly, it is often just the most womanly women who, in respect to certain inner things, have an extreme intractableness, obstinacy and wilfulness which qualities are found in such intensity in the outer attitude of man.

## *Attitudes*

### THE EXTERNAL ATTITUDE (PERSONA)

A definite milieu (or situation) demands a definite attitude according to the obligations and expectations of the individual's occupation or profession. This attitude is a reflection of the person's conscious intentions as they are oriented to the demands of his environment. He may be helped in formulating this attitude by society's generalized conception of what his attitude, character, or behavior should be.

For instance, a minister does not cease to be a minister at the end of his sermon or even at the end of the day. In society's view, he is a preacher around the clock. This external attitude or characteristic type of behavior Jung describes as a mask or persona.

He defines the persona as a function complex which comes into being for reasons of adaptation or necessary convenience.

Fundamentally, the persona is nothing real; it is a compromise between the individual and society as to what a man should appear to be. Much of our common humanity is sacrificed in an effort to mold ourselves into an ideal image. The persona is that compromise role in which we parade before the community.

Since many are obliged to move and function in two or more totally different milieus such as the family and the world of affairs which demand dissimilar attitudes, totally different behavior may be required in the two circumstances. A man may be aggressive, inconsiderate, and demanding in his business but at home he may be mild, accommodating, and good-natured. Which of the contrasting aspects represents the true character may be impossible to answer.

Jung feels the more the person's individuality is developed, the more consistent his character and the less it will vary with each momentary change of circumstance. The persona is the obvious relationship of an individual with outer subjects.

### THE INTERNAL ATTITUDE (THE ANIMA OR ANIMUS)

In addition to the individual's relationships to outer objects which Jung described, a similar but less evident subjective state

exists with the inner object, that is, the unconscious. This relationship or 'inner attitude' is of equal or greater consistency (being less amenable to alteration) and is termed the anima or soul. This anima or soul is considered a circumscribed entity and maintains a complementary relation to the outer character.

The male has a feminine soul, the anima, and the female has the male counterpart, or animus. Jung states the persona and anima are symbolically represented in dreams. The persona is embodied in prominent dream figures of the same sex who possess the outstanding qualities of the persona itself. With men, the soul (or anima) is represented in the person of a woman, with women, the dream presentation of the unconscious is in masculine form.

Normally a male should project his soul image onto a woman. A man in his love choice is strongly tempted to win the woman who best corresponds to his own unconscious femininity. This choice is usually regarded as ideal, it may with time become apparent that he has obviously married his own worst weakness.

#### INDIVIDUATION

This is '... a process by which a man becomes the definite, unique being he in fact is.' Jung says this evolving proceeds somewhat as follows. The person becomes aware of his own inner duality; he no longer accepts his own compromise or persona as the whole of self; the opposites which exist within him are harmonized and he ceases to be bound by the absoluteness of all things material with a denial of all else.

#### *The Introvert*

Being governed primarily by subjective factors, the introvert's response to what he perceives is determined more from within than without. Unconscious factors produce enduring tendencies or definite ways of looking at things. The world exists not merely in itself, but also as it appears to me. There is a movement of interest away from objects to the subject; consequently the introvert gives himself a higher value than the object.

The introvert may be taciturn or fall among people who cannot understand him, which only feeds his convictions of the unfathomable.

able stupidity of man. Such persons are frequently silent, inaccessible, and painfully brief. They may hide a melancholic temperament behind a banal or childish mask. Their attempts at clarity may be clouded by interminable qualifications, doubts, accessory explanations, and hedging.

The subjective orientation of introvert thinking brings about a negative relationship with aversion or indifference to what he perceives externally. In Jung's wording: "objects possess terrifying and powerful qualities for him, qualities which he cannot consciously perceive," but in which he cannot avoid unconsciously believing. In those extremely introverted, the stimulus from without is replaced by a subjective reaction which may be only generally related to the reality of the subject. Such a type can easily make one question why one should exist at all, or why objects in general should have any right to existence, since everything essential happens within the subject.

The determination of which personality type a child develops appears for the most part independent of external conditions and must, in the last resort, be ascribed to individual variations. Jung points out that when introverts and extroverts marry, they fit together admirably as long as external needs persist and they can stand back to back, facing the pressures from without. But when success brings relief from previous demands and they face each other, they speak a different language. They are strangers who have never understood one another. The struggle which ensues between them is envenomed, brutal, full of mutual depreciation, even when conducted quietly and in greatest intimacy, for the value of one is the negation of value for the other.

### *The Extrovert*

The extrovert is characterized by an outgoing, candid, and accommodating nature that adapts easily to situations, quickly forms attachments, and ventures forth with careless confidence into the new and unknown. With such people there is an outward movement of interest towards the object; this attraction to objects may transform and determine the subject by their assimilation and significance.

When an individual's essential decisions and actions are determined by his relation to objects rather than subjective values, one speaks of an extroverted attitude. If this attitude is habitual, the individual is an extroverted type. His subjective values lack determining power as compared to external objective conditions, the persons and things which attract him govern his actions.

The extrovert may be caught up, swept along, or lost in the objects which attract him. This is his danger. He is never free of the environment to which he so adequately responds, as it moves he moves whether to advantage or disaster. Such a person's body is insufficiently external to be of interest and is only noted when 'abnormal bodily sensation make themselves felt.' "His aim is concrete enjoyment and his morality is similar oriented."

Extroversion is a positive movement of subjective interest towards objects, an outward turning of the libido. An extrovert's thinking tends to be positive and productive. His appreciation of objects allows him to bring things together in a more purposeful order, to synthesize a complex from the parts, but once this is accomplished his interest may wane.

Stability and lack of change may bring an air of suffocation to the extrovert who then seeks new possibilities with great enthusiasm. The recently new may in turn be dropped cold and bloody and apparently without remembrance as it is completed, or becomes static and devoid of further possibility of development. The abilities of man may be intuitively appreciated and the extrovert's ability to inspire others with enthusiasm for the new "is not a mere histrionic display, it is a fate." An intuitive extrovert may squander his days 'animating men and things, spreading about him an abundance of life—a life, however, which others live, not he. In the end he goes away empty.

*Differences between Jung's "Analytical Psychology," "Psychoanalysis," and Adler's "Individual Psychology"*

Jung's early reluctance to accept the predominance which Freud gave sexuality is reflected in his concept of libido, which he defines as 'synonymous with psychic energy or the intensity of the psychic processes. This is in contrast to Freud's meaning of libido as the representative of the sexual instinct in the mind.

Jung's concept of psychic energy derives from "the play of the opposites" in much the same way as physical energy involves a difference of potential. This problem of the opposites may exist between "the sensual and the spiritual, or the ego and the shadow," and in neurosis an inner cleavage was said to occur, with the individual at war with himself.

Jung states his evaluation of sexuality as follows: "I do not mean to deny the importance of sexuality in psychic life, though Freud stubbornly maintains that I do deny it. Rather, Jung says he merely insists on setting bounds, of putting sexuality into its proper place and concludes sexuality is "only one of the life instincts—only one of the psycho physiological functions."

Jung did not agree on dream interpretation as the following shows: "The manifest dream picture is the dream itself and contains the whole meaning of the dream. I find sugar in the urine, it is sugar and not just a façade for albumin. What Freud calls 'the dream façade' is really the dream's obscurity and this is really only a projection of our lack of understanding." He does not hold that dreams are prophetic but feels they do "anticipate or reconnoitre" the future.

According to Jung: "The two theories of neurosis (Freud and Adler) are not universal theories, they are caustic remedies to be applied, as it were, locally." Noting the theoretical differences in the two approaches but agreeing that both were "in a large measure correct," he concluded neuroses must have two opposite aspects with each investigator seeing the factors that corresponded to his own peculiarities.

Jung describes Adler as unduly emphasizing the subjective aspects and the superiority of the subject in his theories: "The individual appears pre-eminently as an ego point which must under no circumstances be subjected to the object." This is contrasted to Freud's emphasis on specifically significant objects (that is, father and mother) and sexuality. The sexuality expressed the strongest relationship between the subject and the object. For Freud the subject blindly strives after pleasure but the quality of this striving is derived from the objects which possess the determining power. The subject is the source of desire for pleasure and the "seat of anxiety" but otherwise lacks significance.

Jung says that a middle view, possibly one of common sense, might be more tenable, since human behavior is conditioned as much by the subject as the object. He does not agree that reduction of symptoms to their unconscious origins is sufficient, particularly during the latter half of the patient's life. He repeatedly stresses the importance of a synthesis following the reductive process which occurs in analysis.

Jung points out that the repression of unmoral instincts is insufficient to explain emotional illness since a life of unrestrained instinct provides no immunity against neurosis; such an individual only represses his morality. Morality is seen as existing at all levels of society as "an instinctive regulator of action which governs the collective life of the herd." This morality "was not brought down on tablets of stone from Sinai and imposed upon the people, but it is a function of the human soul, as old as humanity itself."

Jung sees a lack of motivation, an inner purposelessness, as a primary problem in "people who have left a large part of their life behind them." In youth, a liberation from the past may be sufficient motivation; the future "the life urge, will do the rest." But those with little left except "old age and the end of all illusions" can hardly desire more of which they have already had too much.

The problems of the latter half of life and the lack of preparation for these years are repeatedly emphasized by Jung, since two-thirds of his patients are over age 35. The step into "the afternoon of life" is taken with the false presumption that the goals, ideals, and truths previously adequate will be as satisfying in the ending of life as they were in the beginning. This, Jung says, is false, "for what was great in the morning will be little at evening and what in the morning was true will at evening have become a lie."

It is pointed out that in the United States in particular, the old attempt to compete with the young—the father becomes the brother to the son; the mother, if possible, the older sister of her daughter. The need for an enduring future goal is essential for those who approach old age without having lived sufficiently, since for them to look back is particularly fatal. As a physician, Jung holds it hygienic "to discover in death a goal towards which one can strive and that shrinking away from it is something unhealthy and abnormal which robs the second half of life of its purpose."

Few comprehend why the body needs salt but all instinctively demand it similarly, a large majority from the beginning have felt the need to believe in continuation of life I therefore consider it wiser to acknowledge the idea of God consciously for if we do not something else is made God usually something quite inappropriate and stupid such as only an enlightened intellect can hatch forth

Jung concludes modern man has heard enough of guilt and sin and is less than eager to imitate Christ but wants instead merely to live his own individual life meager and uninteresting though it may be He desires wife and offspring a standing or esteem among the herd innumerable commonplace realities and not least those of the Philistine

Jung says his analytical psychology is a general concept embracing psychoanalysis individual psychology and other endeavors in complex psychology He places much greater stress than either Adler or Freud on the influence of the physician's personality on the patient and adds The personalities of the doctor and the patient are often infinitely more important to the outcome of treatment than what the doctor says and thinks You can exert no influence if you are not susceptible to influence The physician should apply to himself the system he prescribes

Jung notes that his insistence on the need to rediscover the life of the spirit has resulted in his being branded a mystic He answers this by saying those of the Freudian school as well as its founder so fanatically defend the father-complex that it becomes a cloak for religiosity misunderstood He adds that Freud's super ego concept is but a furtive attempt to smuggle in his time-honoured image of Jehova in the dress of a psychological theory and that Freud shipwrecks on the question of Nicodemus can a man enter his mother's womb a second time and be born again?

Freud's theory is said to rest on reductive explanations which inevitably lead backward and downward It is the most effective antidote imaginable to all idealistic illusions about the nature of man It is pointed out that Adler has shown convincingly that many cases of neurosis can be more adequately explained as an urge to power than by the pleasure principle Adler's method of



treatment is most suited to repressed and socially unsuccessful people whose one passion is for self assertion

### ALFRED ADLER (1870-1937)

Adler, a Viennese, was one of those early attracted by psychoanalysis, but after approximately nine years of association, the disagreements and rivalry between him and Freud led to an open break. In 1911, Adler and nine other members withdrew from the Psychoanalytic Society and founded the Society for Individual Psychology

Adler postulated an "imagined goal" which after the brief period of childhood dominates all subsequent temporary objectives. This orientation toward some final goal in turn establishes an individual's life plan. A knowledge of a patient's life plan allows the physician to predict, in a general way, what will happen to the individual

Adler further stated: "We cannot think, feel, will, or act without the perception of some goal. Without this controlling goal the economy visible in our psychic life would be unattainable, and we would persist in a stage of amoeboid groping, in a planless chaos."

An awareness of this goal and 'life plan' is essential to rational treatment; otherwise psychic phenomena are without relatedness and contribute little to an understanding of the person. Similarly, psychic processes 'torn from their proper context' have such a multiplicity of meaning that an evaluation is impossible without an intimate knowledge of the whole individual.

Adler insisted that regardless of 'tendencies, milieu and experiences' all psychical powers are under the control of a directive idea, and all expressions of emotion, thinking, dreaming and acting are permeated by one unified life plan. Up to the present there is not the slightest proof that either heredity, experience or the environment 'necessarily lead to a general or specific neurosis'. He adds that these heretical propositions may be made less harsh by the following: 'More important than tendencies, objective experience and milieu, is the subjective evaluation. This subjective evaluation may stand in a strange relation to reality but from it there

generally develops a permanent mood of the nature of a feeling of inferiority \*

The masculine protest arises in opposition to inferior passive or submissive feelings which Adler equates to feminine stirrings and sensations. This masculine protest he considered the main motive force in neurotic disease. Feminine stirrings may in turn provoke an exaggerated masculine protest in the male and a denial of femininity in the female.

The psyche has as its objective the goal of superiority whether a person wants to be first in his profession to be a tyrant in the home to converse with God or to chase after unattainable ideals he is driven and guided by his longing for superiority the thought of his godlikeness.

He may gain this superiority directly by dominance bravery or cruelty or he may prefer or by experience be forced to the circuitous routs of obedience submission mildness and modesty. Were this goal of superiority not present why should the needs to minimize and undervalue others exist? Why should there be a need to feel envy avarice intolerance and pleasure in the misfortune of others to a far greater extent than self preservation demands? The healthy and ill alike posit a life goal and evolve a life plan adjusted to it. Those ill develop a greater safeguarding tendency.

This safe-guarding tendency may be exhibited when necessary decisions are delayed or avoided. A decision which in any way threatens prestige may be met by a hesitating attitude or a goal is approached by an indirect delaying circuitous route so that distance is created between the consideration and the need to hazard safety by a decision. Adler stresses this same hesitating attitude and the creation of distance in compulsive behavior which consumes time by ritual and avoidance to escape a decision or a responsible act.

Adler places the goal of complete superiority with "fiction" and

\* According to Brachfeld it was not until 1926 when Adler was in the United States and learned that he had been called the "father of the inferiority and superiority complex" that he used the terms which he had earlier rejected because they had a definitely Freudian ring.

'imagination,' apart from the world of reality. But such a goal is a principal conditioning factor in life, it teaches us to differentiate, moulds and guides our acts and "forces our spirit to look ahead and to perfect itself."

This goal of superiority destroys the simplicity of our feelings, puts near our hearts the idea of attempting to overpower reality," and introduces a hostile and a fighting tendency. Those who would take seriously or literally this goal of godlikeness cannot tolerate the compromise of the ordinary life but seek instead "a life within life" in pietism, art, neurosis, or crime.

In the neurotic this unconscious goal of superiority and its contradictions do not enter awareness, otherwise the prestige the superiority demands would be destroyed. The patient instead attributes his failures to fate, protects his position by a 'hesitating attitude' which avoids decisions and thereby the responsibility of failure. This failure must result from causes beyond self that will not increase his underlying inferiority. Finally, the patient reconciles himself to life by accepting "symbolic success" and concluding "If conditions had been different" or if fate had not intervened, then he would not have failed.

A clear indication of this supermundane goal is to be found in every individual; it indicates a striving for power in every bodily and mental attitude, carrying within itself a kind of perfection and infallibility. The neurosis provokes a striving (or will) to power to enhance self-esteem. Adler's view in many points agreed with older authors to whom a sense of pleasure was founded on a sense of power, and displeasure, on a feeling of weakness. The compensatory force of the will to power derives from a need to end a general human feeling of inner insecurity.

Adler termed his system "Individual Psychology," the basic principle in the practice of which was "the retracing of all nervous symptoms occurring in an individual case back to their lowest common denominator." The psychic foundations and symptoms of neurotic illness are taken over unchanged from childhood, but through the years a concealing superstructure is added which includes developmental tendencies, character traits and personal experiences. Of particular importance are the single or repeated failures and the mood residues which these failures engender.

If inherited inferiorities of organ or function are felt psychically, a neurotic disposition is introduced; a child with such an experience feels "a sense of inferiority in relation to his environment," and uncertainty in his psyche. The decisive factor in such an occurrence is the situation in which the child finds himself, and his appraisal or evaluation of his position in this situation. The psychogenic factors are considered primary, and the constitutional (or organ) inferiority is secondary.

The comparable inadequacy of the child to the adult during an extended period of development is the source of the feelings of inferiority. This is disturbing but tolerated by the healthy child; in contrast, those unhealthy and in a vulnerable situation develop neurotic character traits and symptoms.

A subjective feeling of inferiority in an organ or function induces psychic efforts at compensation. Adler cites as examples the myopic's wish to see well, the slow-moving and last-born to be first in all subsequent endeavors, the awkward's need to make haste.

The neurotically disposed child early manifests ambition and conceit, and the desire to have all attention focused upon him by either good or bad activity; but the underlying feeling of insecurity and inferiority forces its way through easily as fear and timidity. This inferiority may be manifest as a desire in the child "not to be left alone," or for help which is demanded with an irritable hypersensitiveness. The opposite may occur in which pity and sympathy are sought as protection against the possibility of humiliation.

The neurotic's hypersensitiveness and intolerance lead him to avoid the larger unit of the social group in favor of the isolation provided in the small family circle. Such a patient attempts to sidestep the demands of reality in favor of an ideal and superior position, free of responsibility and the hazard of failure. The neurotic illness in turn becomes a substitute for an exalted goal and at the same time an excuse for its remaining unattainable.

The neurosis establishes a defense against the constraints and requirements of the community by the erection of a stronger "counter-compulsion." This "counter-compulsion" assumes the form of a revolt against society's demands and strengthens itself by the addition of favorable affective experiences and observations.

The attention of the patient is thus turned away from his "life problems" as he becomes increasingly more preoccupied with his illness, his discomforts and his complaints, until the "counter-compulsions" outweigh logic. The unbearable compulsions of an inimical external world may be solved transcendently by treating all else, particularly other human beings, as mere appearances—the patient continues as though he were the only living being in existence.

The psychic life of the neurotic, far more than the ordinary man, is arranged in accordance with his desire for power over others. His longing for superiority, in turn, allows him continuously to reject "all outside compulsion" and to seize with unaltering regularity the means of utilizing his illness to triumph.

"All the volition and all the strivings of the neurotic are dictated by his prestige-seeking policy, which is continually looking for excuses to leave the problems of life unsolved." The patient's attitudes, established in childhood, continue to be dominated by this early relationship to his environment, an erroneous and usually generalized self-evaluation, and by a persisting and deep-rooted feeling of inferiority.

In a schematic picture of the neurotic's orientation the only definite and fixed point conceived of is the "personality ideal." This "personality ideal" is based on the neurotic's tendentious evaluation of his individuality, his experiences and his environment. This erroneous evaluation fails to bring him nearer his goal so he "provokes experiences" to justify his failure. As he fails, he feels deceived, he suffers, and his aggression is fed.

From such selected real experiences and unrealized possibilities, he constructs character traits and affect-preparations which fit into his personality-ideal. It is a categorical command of his life-plan that he should fail either through the guilt of others, and thus be freed from personal responsibility, or that some fatal trifle should prevent his triumph.

#### *Differences between Individual Psychology and Psychoanalysis*

Adler describes innate social interest or feeling as a primary phenomenon as "organically determined impulses of affection" which

are evident early in life 'One can always observe that the child directs impulses of affection towards others and not towards himself, as Freud believes'

He stated the child and the mother were dependent on each other and that those who maintained the child entered the world with a 'drive for destruction' and with the intent to foster himself cannibalistically on the mother, erroneously based their inferences 'on incomplete observation'

The form and content of the neurotic life plan were said to arise from the impressions of the child who feels humiliated' Subsequently, neurotic traits were sought as a means of excluding permanently a repetition of these humiliations Social interest was stressed as the barometer of the child's normality and as "the criterion which need be watched"

The dream was seen as an effort to solve an anticipated problem, which was understandable if the therapist appreciated the 'unity of the personality' which does not allow any loss of self esteem The activity in the dream as in conscious behavior, conforms to the patient's life-plan Adler considered the explanation of the dream as an attempt to fulfil infantile sexual wishes as untenable as the sexual basis of neurotic disease

An individual's life plan by which he hopes to dominate the processes of life and his own feeling of uncertainty is unconscious His dreams reveal the detours he makes in conforming to this life plan because of 'feelings of insecurity' as well as to avoid defeat A goal or guiding idea never becomes unconscious because of a suppression of sexual impulses or complexes', but rather to safeguard the personality ideal and maintain its unity This is accomplished by placing the goal beyond the hazard of conscious testing and its possible destruction or belittlement

The concept of the 'neurotic's taking refuge in illness' Adler considered manifestly wrong and added that the secondary hypothesis of a deficiency in wish fulfilments or 'libido' did not lend support to the theory The neurotic's feelings of inferiority are evident in all his activities including his sexuality, but the sexual role is relegated to one of minor importance

Adler accused Freud of circular reasoning in his explanation

of repression, namely, that repression takes place under the pressure of culture and culture in turn results from repression. He points out that Freud attributes neurotic illness to trauma which strengthens repression and activates an old conflict. Adler disagreed and said the neurotic suffered continuously, but that either an actual or anticipated disparagement would provoke an acute episode, and if new "drive repressions" appeared, they were only incidental.

Neither was he in accord with the theories of infantile sexuality. He noted: "I have seen many patients who have come to know their Oedipus complex very well without feeling any improvement." The Oedipus complex is regarded as only a small part of the "neurotic dynamic," a state of the masculine protest which is instructive but insignificant of itself.

Freud, on the other hand, regarded Adler's approach as being concerned with surface phenomenon or ego psychology, and thought his methods were general and did not pertain to libido. Freud added that Adler was forever mixing up what was primary and what was secondary, that he never discovered, only reinterpreted, and that despite Adler's disagreement with the idea that 'the core of a neurosis is the anxiety of the ego confronted by libido, his writings only served to reinforce this conclusion.'

### Summary

Adler's 'Individual Psychology' presumes an "imagined goal" which in turn evolves a 'life plan' that gives direction and purpose to an individual's behavior. The neurotic erroneously evaluates himself, his experiences and his environment and establishes a "personality ideal" which fails to bring him nearer to this imagined goal. This continuing failure leads him to provoke experiences to justify and explain his failures, and to construct character traits and select real experiences which fit this erroneously determined 'personality ideal'.

'Individual Psychology' stresses *subjective evaluation* as being of greater importance than objective experience, milieu, or tendencies. The prolonged dependence of childhood and the comparable inadequacy of the child to the adult lead to feelings of inferiority.

The feelings of inferiority, if psychically felt, may provoke efforts at compensation which, if sufficiency exaggerated, exist as symptoms

Adler equates a dominant, secure, 'above' position to masculinity as opposed to a submissive, dominated, or 'below' position to femininity. An awareness in the male of feminine tendencies may provoke an exaggerated show of aggression or a 'masculine protest', similarly a female may deny her femininity and assume an aggressive masculine attitude.

Since Adler places the 'goal of superiority' as the objective of the psyche, the masculine protest would arise as this objective was frustrated or threatened. This goal of superiority may be gained directly in elevating self or indirectly by depreciating others, both tendencies are particularly marked in the neurotic.

Adler did not agree with Freud as to the importance of the sexual instincts, repression, the unconscious, or the Oedipus complex. The patient was studied as a part of his environment and particularly the subjective evaluation the patient made of the situation in which he found himself.

### SANDOR FERENCZI

Ferenczi suggested that on occasion the analyst has need to show 'a certain degree of activity'. He felt this activity is indicated when "the patient makes himself at home" in the treatment situation or during "the comfortable but torpid quiet of a stagnating analysis".

This activity is clarified as follows. The instructions given the patient are not concerned with the spiritual, practical or moral aspects of his life but are directed only against the pleasure principle. Essentially, what the patient feels he requires is opposed, and where he is inhibited he is instructed to be more active. By this activity, Ferenczi hoped to redistribute the patient's psychic energy primarily his libido.\*

He also advocated setting a time limit on analysis. This he saw

\* Freud (1919) in discussing this suggested modification in technique by Ferenczi agreed that in so far as possible analytical treatment should be carried out in a state of privation or abstinence. He added that since frustration had made the patient ill that improvement diminished the instinctual energy impelling him to a cure. If the patient is too early comfortable the treatment may prematurely end.



as a check-mate which closed all avenues of retreat except the one leading to recovery.

In addition to resolving conflict and decreasing anxiety, Ferenczi stressed the need to increase the patient's ability to tolerate tension. This is of particular importance in the individual who has impulsively sought immediate relief of all tension, whether physiological or psychic, throughout his life.

The patient who cannot tolerate tension without immediate discharge—whether it is in the mind or the bladder—may be instructed to attempt to control his urinary frequency. From an awareness that he can control his sphincters (and his tension), an air of self assurance and freedom may arise which is consistently absent in the neurotic.

Ferenczi stated that the physiological and biological significance of the sphincters may have been underestimated. He points out that anxiety is usually accompanied by an anal stricture and a tendency to empty the bladder; and in hysteria this stricture may be displaced as in globus hystericus or spasm of the pharynx.

The benefits of inhibition during treatment are also related to the semipotent or partially potent male whose efforts far exceed his desire. As a consequence of his inability, such a male may be irritable or of bad temper towards his wife or show neurotic symptoms. Nothing jeopardizes a marriage so much as a pretense of greater tenderness or eroticism than actually exists; and this strain is further aggravated by the suppression of hate or other painful feelings such a pretense demands.

Ferenczi notes that intercourse, by its nature, is not a deliberate act nor a matter of use and want but rather an archaic method of release of dammed-up energies, a celebration.\*

#### HARRY STACK SULLIVAN (1892-1949)

Sullivan stressed the importance of interpersonal relationships in the understanding of the patient and his difficulties. He felt that a human required the world's cultures and was only human as he was in communal existence with it.

\* This is a refreshing observation since too frequently something akin to "intellectual intercourse" carried on at an atraumatic verbal level is described.

To maintain security the individual evolves the self. This self is in large measure determined by significant others. What these significant people approve become part of the personality and those tendencies of which they strongly disapprove are largely dissociated.

This self controls awareness, restricts attention to the relevant and serves to maintain self-esteem and a feeling of competence with others. The self is composed of memories, processes and past experiences which together offer understanding of the relatedness of events experienced by the individual.

Sullivan disagreed with the concepts of the personality's three units (id, ego and superego) whether these units were considered hydraulically, mechanically, topographically or allegorically. To avoid the hazard of a misunderstood analogy he used the word dynamism where others used mechanism.

He also mentions that much of what is said to be repressed is merely unformulated and that anxiety is evidence that either one's self-esteem or self-regard is in danger. In regression the causative factors may be difficult to elucidate since the ability to talk about them also regresses.

Parataxic distortions are morbid, undigested experiences of the past which have never been integrated into the unity of the self. Such distortions in both patient and therapist may interfere with interpersonal relationships if they are not understood. Sullivan described empathy as the peculiar emotional linkage that subtends the relationship of the infant with other significant people.

### *On Interviewing*

Sullivan's suggestions on the technique of interviewing and the methods of psychotherapy are excellent. He was more concerned with what could be done for the patient than what had happened to him in the past. The outstanding difficulties in living which the patient is experiencing and the possibilities of a good life after favorable change are held as the frames of reference in considering prognosis and treatment. These frames should be established before formal psychotherapy is initiated.

There is an abiding need to make clear what the patient means by what he says. The more conventional a person's statements, the greater the doubt that the interviewer will have any idea of what he is attempting to convey.

Sullivan also advises against handing out "bromides from the culture and psychiatric banalities," adding that he would defy anyone to determine what they mean. As an example, he describes the term "mother fixation" as a beautiful abstract idea, most useful in psychiatric rumination, but to the patient having a mother fixation the term is devoid of meaning and no more than clap-trap.

The patient seeks the psychiatrist's help for his presumed expertness and not to have him become involved in the treatment as a person. His training and experience lend him uniqueness, but neither omnipotence nor clairvoyance. Therefore, the psychiatrist should cultivate humility rather than attempt to impress the patient that all is revealed to the penetration of his glance.

During the interview three things should be happening: The psychiatrist should be considering what the patient may mean by what he is saying; what he, as a therapist, is to reply to the patient; and at the same time, he should be observing the general pattern of events being discussed. Sullivan concluded that to do these three things and take notes at the same time was beyond the abilities of most human beings.

After some understanding of the patient is obtained, the physician should surmise what "alternative probabilities" may explain what he has learned.\* It does not matter if the psychiatrist has a dozen "alternate probabilities," provided he has more than one. If he has only one formulation, he is "operating on faith, which is a method of performance characteristic of those who never pause to doubt their heaven-sent ability to know all about another person by talking with him for five minutes."

Sullivan recommended that after 7 to 15 interviews the psychiatrist briefly summarize for the patient his impression of the history and the sequence of events that culminated in the present difficulty. This suggestion has much to recommend it since the therapist has

\* This is not unlike the process of establishing differential diagnoses

to formulate his impression in a concise understandable manner, and the patient hears, usually for the first time, an opinion of his "over all" problem rather than an interpretation of a fragment Sullivan emphasized that this summary also revealed discrepancies that might exist between what the patient meant and what the therapist understood him to mean

### KAREN HORNEY (1885-1952)

Karen Horney emphasized the importance of the culture, the environment, the patient's character, and his seeking after safety, to the development and pattern of neurotic illness. Although her objections to Freudian theory were not unlike those previously stated by Adler, she wrote that in spite of the similarity between her concepts and the points stressed by Adler, her "interpretations rest on Freudian grounds

Horney's dynamic concept of personality assumed that emotional forces motivated attitudes and behavior, and the understanding of personality structure required the recognition of emotional drives of conflicting character. The neurotic is easily frustrated because his expectations, which are prompted by anxiety, may be contradictory, excessive, and impossible of fulfilment. Too his wishes may result from an unconscious desire to dominate and triumph maliciously, consequently, frustration is experienced as further humiliation.

"Basic anxiety" apparently results when the meaningful adults in the child's environment are so concerned with their own neuroses that they are unable to love him as a child. The attitude of such parents, being determined by their own neurotic needs, prevents their offering the affection and security a child requires.

In such a situation the child conceives of the world as being hostile and competitive, he feels isolated and in need of a feeling of identity. Since reality fails to satisfy his needs he creates an 'idealized image' of himself which in time becomes an 'idealized self'.

This self idealization which supplies the individual's inner needs while avoiding painful and unbearable feelings, Horney refers to as the "comprehensive neurotic solution." Subsequently, energy which would have been spent on self realization is directed instead

to efforts at actualizing this idealized self. These efforts (to accomplish this actualization of an ideal) explain the need for perfection, the neurotic ambition, and the hope for vindictive triumph—literally, the “search for glory.”

The neurotic drives arise compulsively from within. They take their origin from the ideal rather than the real and are therefore insatiable (that is, cannot be externally gratified).

The seeking after an ideal self leads to an alienation from the “real self” with an increased remoteness of the individual from his own feelings, wishes and beliefs; if sufficient, this remoteness is experienced as a depersonalization. The more driven the individual to realize this ideal self, the more he is motivated by what he “should” do rather than what he wants to do. This Horney refers to as the “tyranny of the should.”

This attempt to escape “crude reality” by attaining perfection may lead to the real self’s being despised as the cause for failure, with “self-hate” or “self-contempt” as the consequence. Tension may be relieved by an impersonal attitude towards self, by externalizing or by isolating inner experiences.

The main source of anxiety is seen as hostility. An awareness of animosity in self may be met by a restriction of its expression due to the following: the reality of the circumstance; simultaneous feelings of affection as well as anger, with both eventually being integrated into the totality of feeling; and finally, an expression of hostility which may be restricted by the weight of what is understood as appropriate.

The neurotic’s basic anxiety requires that he seek affection, but his self-contempt makes him distrust any affection shown for his “real self.” He may seek affection by a submissive and compliant attitude which only serves to make him despise himself the more. In brief, the method he follows in gaining affection may aggravate his basic hostility and subsequently his anxiety, and so the process is perpetuated.

The neurotic’s striving for power, prestige and possessions protects him against anxiety, and at the same time offers a means to discharge hostility. This prestige may be gained by the humiliation of others as well as by excelling. This compares closely to Adler’s

"will to power" and his "goal of superiority" which may be obtained by elevating self or depreciating others. Horney states that neither Adler nor Freud saw the role of anxiety in such drives nor were they aware of the cultural implications.

The neurotic is trapped by his contradictory imperative needs for affection, on the one hand, and his need to dominate on the other. Inferiority feelings may afford a method of avoiding competition and consequently the hazard of humiliation. The fears of disapproval result from the discrepancy between his social facade and his repressed tendencies.\* The individual fears the insincerity of his whole personality may become evident which, in turn, prompts his fear of disapproval.

Neuroses are ultimately an expression of a disturbance in human relationships. Symptoms may vary but the basic problems are strikingly similar. These problems result from conflicts between alienating ambition and an insatiable need for affection, the wish to stand apart and the desire to possess totally, a pride in self-sufficiency and a drive to be dependent, and, finally, the tendency to be unobtrusive and the craving for the envy of admiration.

Horney sees the main objective in therapy as the recognition of the neurotic trends and the purpose they serve in the patient's life, and the consequences such trends have. Treatment should be deliberately conducted by the therapist, and if the patient is taking the wrong track or "running into a blind alley," then the therapist should actively interfere and redirect. The goal of therapy is to help the patient regain his spontaneity, to find his measurements of value within and the courage to be himself.

### *Differences with Freud*

Horney states the genesis of neurosis is neither the Oedipus complex nor the striving after infantile pleasure, but those adverse influences which make the child feel helpless and without defense in a world conceived as potentially hostile.

She does not agree with the Freudian concept of neurosis result-

\* This contrast Jung describes as existing between the outer attitude (or persona) and the inner attitude (or soul).

ing from a regression from a genital to a pregenital level, nor with the explanation that the neurotic who is capable sexually is able to perform satisfactorily only at a physiological level and must be disturbed "psychosexually." This argument is termed fallacious. Sexual problems are considered the result rather than the cause of the neurotic character structure. The sexual functions may be, but need not be, disturbed in neuroses.

As the therapist gains in knowledge and understanding, he is less likely to misinterpret. Erroneous interpretation is further avoided by the therapist's not allowing his observations to be warped by his personal problems, by established theories, or by a conviction of his own authoritative omnipotence.

Horney points out that over-kindliness and generosity may be genuine, as well as the products of a reaction-formation. The libido theory is said to be unsubstantiated. The restriction of the meaning of depth psychology only to those interpretations which establish a connection with infantile drives is termed "an illusion born of the theoretical preconceptions."

Other points of difference between Horney's thinking and Freud's include the theory that a destructive or death instinct was said to be unsubstantiated, contrary to the facts, and harmful in its implications. It was also said that actual infantile experiences to which peculiarities were related were frequently too isolated to explain anything.

### EXISTENTIAL ANALYSIS

Existential analysis is more widely known to European than American psychiatrists, but lately there has been increased professional interest in the method here. A part of the obscurity arises from the philosophical rather than medical origins of existentialism. Possibly a greater part of the obscurity results, as Ellenberger points out, from the phenomenologists having written in such a lengthy and diffuse manner that even well-trained, German-speaking psychiatrists have difficulty understanding them.

The first to be primarily concerned with existence in his philosophical writings was Kierkegaard (1813-1855), a Danish minister. He wrote of the fundamental existential experience of "dread" in

the individual's consideration of "nothing" At the time of his death, his efforts had excited little interest

Karl Jaspers (1883— ), a German psychiatrist and philosopher, shared the renewed interest in Kierkegaard in the present century He described a philosophy of existence as a way of thinking which uses and transcends material knowledge to allow man to again become himself

He introduced the phenomenological method into psychiatry Using this method the examiner attempts to arouse in himself an experience similar to the patient's If he is successful in evoking the experience in himself, it then becomes available to introspection and so possible to describe By evoking several of the patient's experiences in himself, the examiner may comprehend the relationship existing between them

By these efforts, the patient's inner life history becomes available this history is not composed of actual events, but rather how the individual experienced what occurred to him Jasper's phenomenology concerns itself with the data of immediate experience and stresses the activity of the person who is experiencing Experiencing then, becomes an act performed by the person who experiences

Heidegger (1889— ), a philosopher, wrote *Being and Time* (*Sein und Zeit*) in 1927 The uniqueness of human existence, according to Heidegger, arises from the being's concern for the being itself (that is, the sole aware existent) Human existence then is 'being in the world' with other existents Time is not a sequence but a temporary state of past, present and future as experienced by the existent Although existence is 'being in the world' with, authentic human existence always implies distance, presumably the isolation of the uniqueness of the individual

Ludwig Binswanger is one of the leading and most popular proponents of existential analysis today To him, 'being in the world' is existence, but this existence takes its essence not from the individual but from the human existence of mankind, human existence in general

More is implied than 'I-myself' as an existent, it is 'our' human existence Man, as opposed to animals is able to set things at a distance, thereby giving them a separate existence This allows man



to differentiate meaningfulness from the orderless, chaotic nature of his environment according to his needs.

Martin Buber writes in a similar vein on the separate existence of objects in man's environment, as contrasted to that of the animal. To the qualities of the existents in his environment, man can add those that might possibly exist or could exist. The totality of all that exists or that he may conceive of existing is the unity that constitutes the world in which man lives.

Man in his experiencing beyond the immediate transcends himself, thereby creating his world. This capacity, beyond the immediate, constitutes man's freedom. Man in his transcending relates with other beings (animate and inanimate) having independent existence. This relationship is immediate and direct and is not available to introspection.

If man fails to relate, the distance becomes solidified. The other existent then becomes an object in experience, but this occurs within "man" and not between "man and his world." The relationship existing within "man" is an "I-it" attitude, whereas that between "man and his world" is an "I-thou" attitude. When this "I-thou" relationship becomes an "I-it" attitude a typical subject-object relationship is established.

Arieti considers schizophrenia from an experiential and a scientific viewpoint. Experientially, he utilizes Buber's concepts of an "I-thou" (and an "I-it") in studying the altered relatedness of schizophrenia; but he adds that this does not presume the disorder is insusceptible to a scientific approach. Man is man because of his existence with, rather than because of, language or consciousness.

In Sonnemann's monograph he writes that "daseinsanalyse" (existential analysis) has nothing to do with a natural scientist at his microscope. Rather, it is a relationship in the domain of thought between persons which refers both to "world." The existential therapist must be true in his personal world encounter, as well as spontaneous and possessed of inner freedom. He must be aware that authentic thought has existence as its source.

Sonnemann points out that in existential analysis ready-made theoretical schema are not forthcoming; the therapist must accept engagement of self in the phenomena. An interpretation of "being"

can only follow a determination "by being" of the "who" of the existent. The "what" of the existent's world must be similarly experienced. Presumably, the encounter entails a degree of experiencing the patient's world which thus being active is the affirmation of a risk.

There seems to be accord that dread is an existential crisis. Dread is distinguished from fear by the fact that fear is a response to a threat and dread results from the consideration of "nothingness." An awareness of "nothingness" is said to evolve when being considers not-being. In human existence "nothingness" is anxiety and takes its reality from the fact it is encountered in dread.

### *Summary*

Like experiencing, existential analysis (*daseinsanalyse*) does not lend itself to descriptive ease. The difficulty in understanding phenomenology is increased by the different, and at times individual, meanings given to words by those of this persuasion. The apparently obscure or paradoxical, though profound, style of some of the original work allows room for considerable interpretation by both reader and translator. These philosophical differences are not matters of medical concern, but the stress on the patient's experiencing rather than on the event which he experiences is important in therapy.

An appreciation of the patient's "subjective evaluation" (Adler) of what happens to him, or the manner in which he experiences the event that gives it significance, is essential to understanding. This is in contrast to the therapist's attempt to determine the meaningfulness of what has occurred to the patient on the basis of the therapist's own experiencing.

# 3

## *PSYCHODYNAMICS*

The Theory of Instincts  
    *Life and Death Instincts*  
    Motivation of Behavior

Parts of the Personality  
    Id  
    Ego  
    Super ego

Concepts of Psychic Activity  
    Evolution of the Theories  
    Development of the Method of 'Free Association'  
    Levels of Psychic Activity  
        Consciousness  
        Preconscious  
        Unconscious

Psychosexual Development  
    Pregenital Stage  
        Oral Stage  
        Anal Sadistic Stage  
        Urethral Stage  
        Phallic Stage  
        Latency Period  
        Passing of Oedipus Complex  
    Genital Stage

## *Psychodynamics*

### **Mental Mechanisms**

**Repression**

**Sublimation**

**Conscious Control**

**Rationalization**

**Compensation**

**Reaction Formation**

**Projection**

**Introjection**

**Identification**

**Regression**

**Symbolization**

**Displacement**

**Dissociation**

**Conversion**

*"The hope is always justified that there may be some degree of correspondence and similarity between the real processes and our idea of them."—BREUER*

This material generally follows the concepts defined by Freud. Where the theories of others are included, the author's name is given.

## THE THEORY OF INSTINCTS

Basically an individual is presumed to be motivated by the need to preserve himself and his species. These motivations are instinctual, primitive, and unlearned and represent an innate propensity or tendency. Such inherent impulses may be broken down into the areas from which the stimulations arise, but in essence they act to maintain the individual and the race according to the dictates of the species.

Freud conceived of an instinct as a stimulus of the mind, arising from within and exerting a constant force experienced as a need. The alleviation of the need satisfies the instinct, and this satisfaction can only be accomplished by an appropriate decrease of the internal stimulation. Instinctual stimulation, being of inner origin, allows no flight or escape as is possible in relieving externally arising disturbances.

Observations of patients with transference neuroses (hysterical and obsessional) revealed the etiology to be a conflict between the instincts of self-preservation (ego instincts) and those essential to the preservation of the race (sexual instincts); these two types of

instincts ego and sexual, were then proposed as primal or fundamental

Further observation increased the knowledge of the scope of the sexual instincts in the following manner they are present during childhood, and in the beginning have to follow the path of the ego instincts since their final fusion and aim is not possible until relatively late in the individual's development, that is, at the time of sexual maturity or puberty

Instincts are considered to have *impetus* (activity or an energy demanding component) an *aim* which is satisfaction, and an *object* or a means whereby satisfaction may be accomplished In addition instincts are able to alter their objects to allow discharge or relief of tension A progression of the sexual instincts during childhood with a final genital localization with maturity was postulated

During the period of development, a too strongly developed attachment to its object or an exaggerated ease of discharge of tension may result in a *fixation* of an instinct with a loss of mobility and cessation of subsequent maturity Frustration later in life may result in a regression to this area as a means of satisfying an instinct similarly, a failure to progress to a genital localization may result in an adult's functioning sexually in a perverse manner at an infantile level

Those instincts reflecting the immediate needs of the individual are of little concern psychiatrically They pertain to the continuation of life and any interference with their satisfaction is directly and obviously evident. An oxygen lack within seconds takes precedence over any other stimulation whether conscious or unconscious a lack of water or food elevates the demand for satisfaction of these instincts to a priority they never achieve in the ordinary course of an individual's existence

In certain cultures these basic requirements continue to present an abiding problem but one of the benefits of repression and the control of aggressive impulse is the economical manner in which the joint efforts of individuals continue to provide for the group's material requirements However the hostility an individual may conceal to allow his being accepted in his particular group may produce tensions which, though less obvious may be much more

an instinct had yet another quality and functioned as a compulsion inherent in organic life to restore an earlier and more stable "state of things." This stability would tend to conserve a previous "organic inertia," rather than impel the organism toward change and more complex development. The goal of life then is death, or the restoration of the stability that the quality of living interrupted. This conclusion was somewhat contrary to previously expressed concepts and was received with restraint by many analysts.

### *Motivation of Behavior*

If the concept is accepted that all behavior is motivated (or determined) either by instinctual impulse or externally arising disturbances, then an individual's activity is understandable as an effort to decrease these stimuli and avoid tension. It has long been postulated that a constancy of stimuli or a homeostatic state is sought by each individual and that he attempts to maintain this optimum condition.

Freud's *pleasure-pain principle* is based on the theory that a decrease of tension is experienced as pleasure, and an increase, as "unpleasure" or pain. The nervous system is seen as a means of mastering, avoiding, or decreasing stimuli. Those externally arising stimuli are soon distinguished as being capable of avoidance, decrease or removal by muscular effort, whereas those not effected by such effort are realized, early in life, to be of internal origin. With the development of the ego and the evolving of the reality principle there also arises an awareness that these same inner needs must be satisfied safely at the expense of the external environment.

### PARTS OF THE PERSONALITY

The parts of the personality are only functions without dimension which are recognizable in the individual by their constancy. They should not be given a discreteness they do not have nor be considered as separate isolated entities.

An individual is presumably acted on by three factors: the forces operating from within (his instinctual needs or id), the forces operating from without (the external environment), and a constantly acting inner force to conform to an ideal self (the superego).

The ego is that coherent, organized behavior with which the individual attempts to gratify safely his instinctual needs at the expense of the external environment according to the dictates of his superego. Jung concluded that "The psyche is a self-regulating system that maintains itself in equilibrium as the body does. Every process that goes too far immediately and inevitably calls forth a compensatory activity."

The ego is influenced from without and within but acts in only one direction, on the external world. Excessive internal excitation is treated as though it arose from without, which allows the ego some measure of defense against it, this is the origin of projection. Whether this excess of stimulation arises from the id or the superego, the individual alters his external relationships in an attempt to relieve it.

Fechner stated that this balance was attended by an awareness of pleasure as it 'approximates to complete stability, and unpleasure' as beyond certain limits it deviates from stability. The physiological limitations of this equilibrium between inner and outer forces were stated by Pavlov as 'Being a definite circumscribed material system, it can only continue to exist so long as it is in continuous equilibrium with the forces external to it.'

Alexander states that life may be viewed as a relationship between three vectors: the intake, utilization, and expenditure of energy. The different stages of life are characterized by the end for which available energy is utilized. In the child that energy not required for growth and a continuing equilibrium is termed surplus energy and is the source of all sexual activity. This surplus energy is utilized for erotic play in the child (when his own energy output for self-preservation is minimal), and in the adult is sublimated in creative activities or expended in biological propagation. The capacity to make the routine requirements of existence automatic tends to conserve energy or to allow its more economic utilization.

Regardless of the particular view taken of this equilibrium in which one attempts to keep himself, the characteristic behavior of the individual and his motivation constitute his personality. This personality may in turn be divided into the following parts: the



*id*, the *ego*, the *superego*. It should again be emphasized these divisions have no corresponding anatomical localization and are determined by their effects and not their dimensions.

### *Id*

The basic drives or instincts (and the unacceptable aggression that their frustration engenders) which strive for an immediate and total satisfaction without concern for consequence compose the *id*.

In the course of development it repeatedly happens that instincts or parts of instincts are incompatible in their aims or demands with other drives which are capable of being combined into the unity of the *ego*. These instincts are cut off and deprived of a means of satisfaction. They persist in the *id*.

Ideas which provoke shame, self-reproach, psychical pain, feelings of being harmed, all of these ideas which an individual would prefer neither to experience nor remember are repressed and remain unconscious in the *id*. These ideas pose a threat to the integrity of the *ego* and are repelled as a defensive mechanism. In treatment this defense is manifest as a resistance to having these ideas become conscious.

Freud emphasized that the mere "intellectual knowledge of the existence" of such ideas did not lead to their repression; but rather what was repressed was the acceptance of such ideas by the individual as a standard for himself, the claims they made on him, or the admission of their existence as an actual part or desire of his own *ego*. Repression proceeds from "the self-respect of the *ego*."

The *id* is also composed of ideas which were never clearly connected with conscious thought, or ideas which were associated with experiences which lost their meaning in reality and for which no memory existed; they may still persist in the unconscious. These ideas may take their origin in dread of anticipated trouble which failed to materialize; a fright which terminated in joy rather than anguish; or other affects which lost their possibility of expression by a change of events (Breuer).

### *Ego*

The *ego* is a coherent organization of mental forces which arranges the processes of the mind in relation to time and reality.

It is in its greatest extent conscious and has as its prime goal the preservation of the individual as an entity. It attempts to discharge impulse economically and safely, direct activity and satisfy the needs arising from the id. This is to be accomplished within the limitations imposed by the superego and society. Finally, the ego is that portion of the psyche which goes to sleep at night (and ponders the meaning of its unconscious dreams the following morning).

The ego combines several factors since it is acted upon by the id, the superego, and the external world. It is first a body-ego, not only of the body surface but a projection of this surface; it controls motility and with this advantage the opposite responsibility of restraining reaction in the face of impulse. The ego develops from the stage of perceiving to controlling instincts and from obeying to curbing impulse.

In relation to external world, the ego has to conform or according to Jung to create a mask (that is, persona) designed on the one hand to make an acceptable impression on others and at the same time to conceal the true nature of the individual. This Jung feels is necessary because society expects every individual to play the part assigned him as perfectly as possible. Therefore a man who is a parson must not only carry out his official function objectively but must at all times and in all circumstances play the role of a parson in a flawless manner.

Finally, it is concluded that since an individual could hardly totally submerge his individuality in these expectations, the development of an artificial personality becomes a necessity and what goes on behind the mask is the individual's private life. This dichotomy resulting from social necessity is seen as having effects upon the unconscious.

### *Superego*

This portion of the personality is of extreme importance in treatment. The superego acts as a censor with the very important function of automatically rejecting behavior which is felt to be inimical or threatening to the ego. It derives from early identification with the parents with an acceptance and incorporation of their standards of behavior by the child. These standards are not

automatically accepted in childhood but are motivated by an effort to avoid criticism, fears of punishment, by rejection, and finally, by fear of mutilation (or organ loss).

These identifications are carried beyond parents to others in authority or in a position to prohibit. Freud postulated that the infantile narcissism surrendered by the child as he was forced to forego the pleasure principle and accept reality was displaced to an ego-ideal or superego. By this displacement an attempt is made to regain the gratification enjoyed by the infantile ego and its narcissistic perfection, before it was confronted with the interminable contradictions and concerns of reality.

These gratifications can only be obtained within the limits established by this superego and as the attainment of this ideal is approached. The higher or more restricting this ideal, the greater the demands on the ego. This superego may be unrealistically restricting with the result that a constant tension exists between the ego and this ideal, or as Jung remarked: "Man can suffer only a certain amount of culture without injury."

This early identification with the parents and their prohibitions, and the introjecting of these qualities into the ego is the foundation of the superego. During the latency period the process continues and is probably only completed early in adult life. Alexander describes a conscious ego-ideal which "contains values accepted in later life which govern conduct"; he also stresses the error of making rigid schematic distinctions between different portions of the personality.

Freud used ego-ideal and superego interchangeably and stated that the repression of the Oedipus complex is the source of this function of the personality. The parents (and particularly the father) were seen as the main obstacle to the realization of the Oedipal wish; and the strength required to overcome this wish was said to have been borrowed from the father; the child erects the father's prohibitions within his own ego.

Alder postulated an "imagined goal" or life-plan which he felt gave direction and purpose to behavior. This goal takes human activity above the stage of "uncontrolled gropings" by giving response a direction and an economy in psychic life, and was con

ceived as being of basic importance in treatment since Adler felt that if he knew the goal of a person he knew in a general way what would happen

## CONCEPTS OF PSYCHIC ACTIVITY

### *Evolution of the Theories*

The inability to explain the presence of irrational symptoms in otherwise rational patients the occurrence of posthypnotic phenomena slips of the tongue and dreams caused doubt as to consciousness being the only or even the most important function of the psyche Charcot's demonstration that hysterical symptoms could be both relieved and reproduced by hypnosis clarified the site of the disturbance in this very protean disorder This demonstration further emphasized the control of forces beyond the conscious awareness of the patient over somatic as well as psychic functions

Breuer in 1880 hypnotized an hysterical girl and following the patient's suggestion allowed her to describe what was uppermost in her mind This description of the traumatic events preceding her illness was followed by a clinical recovery from her motor paralysis and disturbed states of consciousness This result was indeed striking since it was not accomplished by suggesting that she would be symptom free but rather by expressing the previously restrained emotion which had accompanied the events preceding her illness

Ten years elapsed before Breuer, at Freud's persuasion published this and a second case whom they had jointly studied This procedure of expressing the affects associated with traumatic experience under hypnosis was called catharsis It was abandoned by Freud because the lasting success of the method depended on the relationship between patient and physician If friction developed the patient's symptoms rapidly returned and there were too few patients who could be hypnotized to the required depth to accomplish these results

### *Development of the Method of Free Association*

In attempting to overcome these handicaps which somewhat limited the technique of catharsis Freud gradually evolved the method of free association in which unconscious material is pro

duced without the use of hypnosis. The changing of the cathartic method in the direction of "free association" was promoted in part by the following cases.

An early case, 21 year-old Anna O, was described as having a "sharp and critical common sense," this latter quality making her "completely unsuggestible." It was she who referred to the method as the "talking cure" or "chimney sweeping." At times it required "urging and pleading" to persuade her to talk, and then she might only do so after feeling the hands of the interviewer to establish his identity, on other occasions, verbal utterances did not suffice, and chloral in amounts of 5 gm. were required for sleep.

The next case was more suggestible. Frau Emmy Von N, age 40, could be put into a "state of somnambulism with the greatest ease," and was 'put to sleep twice every day' during the course of treatment which lasted a total of 15 weeks. However, in 1892 Freud treated a Miss Lucy R, age 30, who did not fall into a somnambulist state when he attempted to hypnotize her. He then writes "I therefore did without somnambulism and conducted her whole analysis while she was in a state which may in fact have differed very little from the normal one."

Freud then recounted his observations at Bernheim's clinic, where he had been impressed with the possibility of learning the art of hypnosis, but later discovered that his powers 'were subject to severe limits.' He was then faced with either abandoning the cathartic method or utilizing it without hypnosis. Freud also stated that he soon became weary of repeating the assurance and command 'You are going to sleep . . . sleep', and having the patient respond, 'But, doctor, I'm not asleep.' This frequently led to an involved discussion of the particular type of sleep the psychotherapist had in mind, a discussion which was in no wise beneficial.

Consequently, to avoid these difficulties he asked the patient to lie down on the couch, close her eyes and "concentrate", this apparently left the treatment about where it had started, since it had been postulated earlier that the pathogenic memories were either absent from the patient's memory or present in a highly summary form."

Freud describes how he was saved from this dilemma by remem-

bering that he had seen Bernheim produce evidence that the memories during a hypnotic state were only *apparently* forgotten Bernheim had placed his hand on a subject's forehead and insisted she could recall what she ostensibly had not perceived which the patient did This astonishing and instructive experiment served as the model in the treatment of Miss Lucy R

The results obtained by taking the good lady's head in his hands or pressing on her forehead and suggesting that what was desired would come into her mind when the pressure was relieved led him to the following conclusion forgetting is often intentional and desired and its success is never more than apparent This pursuing of Bernheim's demonstration accomplished two ends a method *no longer dependent on hypnotism* was established and insight into the motives of forgetting was revealed Freud apparently gave up hypnotism in 1896 the pressure on the forehead by 1900 and having the patients keep their eyes closed by 1904 The technique of free association then evolved as observation taught and treatment demanded

### *Levels of Psychic Activity*

Demonstration of posthypnotic activity in which a suggestion can be present but inactive (that is beyond the awareness of the patient) and at a given moment enter consciousness as an idea terminating in action led Freud to postulate that an idea may be both active and unconscious Such unconscious ideas may then be said to have a dynamic quality even though beyond awareness

Similarly an hysterical woman may vomit because of the idea that she is pregnant but have no conscious knowledge of the existence of the idea just as the subject who carries out a posthypnotic suggestion does not recall the origin nor the reason for his activity The unconscious idea may then be active affect conscious behavior and yet never enter the individual's awareness

Previous to this concept of a dynamic unconscious ideas were presumed to have a period of consciousness and to subsequently fade as they were worn away or weakened by time The idea or perception was thought to be inactive or latent until recalled to awareness by the proper association or stimulus

### CONSCIOUSNESS

If consciousness is restricted to the concept of that which is present in our awareness or that which is vulnerable to examination by an effort of attention, then the problem of description and limitation of this state is much simplified. This is the area which permits a selective type of behavior or a choice of response to a given situation.

### PRECONSCIOUS

Besides that of which we are conscious, past experiences and ideas which were not originally associated with a disturbing amount of affect or emotion can be recalled to awareness by an effort of attention. These experiences and ideas are considered to exist in the preconsciousness.

### UNCONSCIOUSNESS

In addition to that of which an individual is immediately aware or may with effort recollect, Freud postulated that ideas may exist and affect behavior without entering consciousness. Such ideas would reveal themselves in everyday life as pointless errors of speech, or a forgetting of the familiar, and would compose the content of dreams. The unconscious would also explain the activity of the hysterical individual who behaves as one possessed but can give no reason for her illness, and the compulsive who agrees to the irrational nature of his rituals but cannot but perform them.

The content of the unconscious was said to possess qualities that distinguished it from conscious mental activity. These differences were described as being composed of instinctive impulse—seeking gratification, containing ideas which are not altered by the passage of time—being unaffected by reality, and being regulated by the pleasure-principle alone.

The timelessness of the unconscious is reflected in the patient's tendency during treatment to recall and relive past experiences without regard for the time, purpose, or order in which they occurred. It also appeared that the unconscious was the repository of memory traces—not the verbal representation, but the feeling or emotion which originally accompanied the perception.

The existence of the unconscious is more widely accepted now than it once was, like sin, it is seldom subjectively evident, although it may be quite obvious in others. When one attempts to consider his own unconsciousness, it is rather like Jung's conclusion regarding immortality. 'Statements about immortality can only be made by the living, who, as such, are not exactly in a position to pontificate about conditions beyond the grave'.

Breuer came close to the core of most of the objection to the concept in his section on the *Studies on Hysteria*. What seems hard to understand is how an idea can be sufficiently intense to provoke a lively motor act, for instance, and at the same time not intense enough to be conscious. Breuer explained this paradox as follows. The 'quota of affect' ideas possessed, that is, whether they were accompanied by pleasure or unpleasure, was significant in whether or not they became conscious. Psychical ideational activity 'was divided into conscious and unconscious portions, and ideas (and complexes of ideas), into those which were 'inadmissible to conscious' and those which were admissible. This inadmissible portion Freud said, had undergone *repression* because it was inimical to the ego. Literally, the individual could not tolerate his concept of himself and these unconscious ideas existing together or recognize them as a part of self.\*

There is little doubt that habit removes activity from awareness (Ferenczi), or that repetition quickly establishes patterns of response at the level of opinions and ideas as well as motor behavior. 'A great deal of what we describe as 'mood' comes from sources of this kind, from ideas that exist and are operative beneath the threshold of conscious. Indeed, the whole conduct of our life is constantly influenced by subconscious ideas'†

\* To point up the existence of unconscious motivation it is interesting to ask psychiatric residents why they chose the specialty (it is even more interesting, but less tolerated to put the same question to the staff). The answers are brief, fragmentary and varied but are hardly sufficiently complete to explain the motivation to years of training. The same question is equally interesting when put to other specialists for instance proctologists.

† There is little need to question the fact that a man can dress, have breakfast, kiss his (own) wife goodbye and find his way to work with a minimal demand on his faculty of being conscious but the fact that most of his likes dislikes opinions and even his most coveted individuality is controlled by processes no longer conscious can hardly be so readily accepted—for unconscious reasons.



The following description of the hysterical patient by Freud (1893) clarifies the effects of the unconscious

If I find a person in a condition bearing all the marks of a painful affect, crying screaming, raving, I am led to surmise that a mental process is going on in him of which these bodily phenomena are the adequate expression. In such a case the normal person is capable of telling us what is troubling him, but the hysteric would answer that he did not know, and the problem at once arises. How comes it that the hysteric is subject of an affect of the causes of which he claims to know nothing? If we adhere to the conclusion that there must exist a corresponding psychic process and at the same time believe the patient's assertion when he denies its existence—then indeed the solution is forced upon us that the patient is in a peculiar mental condition in which his impressions or memories are no longer all linked up one with the other and in which it is possible for one memory to express its affect by means of bodily phenomena without the other mental processes the ego knowing about it or being able to interfere

### PSYCHOSEXUAL DEVELOPMENT

At birth a child is capable only of reflex response, with the progress of maturity he gradually distinguishes himself from the external environment and becomes aware of control and responsibility for self. In the beginning then the child has only his instinctual impulses seeking gratification, and his only awareness is of immediate need. At first, he has only an *id*.

Only later does the child distinguish himself as an entity and as sociate other qualities besides relief of hunger with the woman who tends "The breast that had satisfied his hunger becomes the mother who protects him as well. With the passing of time, the mother is no longer totally available. Others compete for this same object—the father, other siblings particularly those born later, and with affection frustration also appears.

As he develops an awareness of his ability to avoid pain and seek pleasure by virtue of his motility and voluntary effort he also comes to appreciate the need to forego immediate pleasure for a safer, though delayed gratification. Response is weighed with an increasing concern for consequence. The pleasure principle then

gives way before the reality principle as the ego is evolved. With this realization that pain from the outside can by effort be avoided there comes another awareness of a second type of disquieting need from which there can never be a flight nor escape by movement—these are the needs that arise within.

Several areas of his body serve two functions—one physiological and one emotional. The mouth, the anus, and the urethra in particular are areas from which alternately disturbing and pleasurable sensations arise. The discontent of hunger is relieved by satiety, the discomfort of distention by the pleasure of evacuation. The parents emphasize these areas in various ways in an effort to provoke in the child the control which society demands.

Feeding of the infant becomes an emotional experience (for some a battleground) where the parents rather than the child may be frustrated and where the nutritional factor in eating may become secondary to the emotional strife for mastery. Later voluntary control of the bowels and bladder brings demands whose only reward is parental approval, which is a different order of satisfaction than that previously experienced when a need was physiologically met. From the second to the seventh year there is a period of increasing awareness of self followed by the discovery that all those encountered are not alike—of the difference of the sexes.

Freud divided the individual's sexual development into two periods: the *pregenital* stage followed by a period of latency with a reactivation at puberty and the development of the *genital* stage. The peculiar diphasic manner or two fold onset of sexual activity in the human, in which there is an early phase of interest followed by an interval of inactivity or latency and a final phase of markedly increased activity beginning at puberty, was held by Freud to be of great importance in the behavior of the adult.

The second phase at puberty is influenced directly by the solutions reached in the early years before the intervening period of latency. The infantile object-choice was but a feeble venture in play as it were, but it laid down the direction for the object-choice of puberty.

## *Pregenital Stage*

### ORAL STAGE (FROM BIRTH TO ABOUT THE END OF THE FIRST YEAR)

The instincts of self-preservation and the sexual instincts are not distinct—the same area, the mouth, serving both functions. During this stage the food and the individual who tends are both incorporated; this is the prototype of identification. The emotion accompanying hunger, the frustration of delay in relief, and the pleasure of satisfaction are all fused into an identification, first with the object which relieves, the breast, and later with the “woman who tends.” This is the *anaclitic object-choice*; literally the sexual instincts “lean against” the instincts of self-preservation for gratification because they lack other means of discharge.

### ANAL SADISTIC STAGE

This begins at about the end of the first year of life and extends to the third year. This stage allows active control through the use of somatic musculature; mastery of the function (and of those attempting to train) may be gained by expelling or retaining the fecal material. The child at this age lacks the revulsion for his handiwork (excreta) which the mother may or may not experience, and lacks the concern his parents feel over failures to control his bowel functions.

During this period an instinct is inhibited in its aim for the first time through the child's effort. Frustration in the form of a demand for compliance and a delay in satisfaction is interposed by the parents. Opposite pairs of instincts of equal force utilizing this same erotogenic area are productive of ambivalence.

### URETHRAL STAGE

A urethral stage has also been described in which the pleasure of retention and of expelling has been postulated as being similar to that occurring in the anal sadistic stage. The duality of innervation with one system leading to withholding, and the other to the emptying of the bladder, is made more complex by adjacent an-

anatomical areas serving both a sexual and excretory function. This close nervous and anatomical relationship may lead to an involvement of both systems by the existence of a pathological state in either, as in frequency, urgency, or impotence in the anxious. This was also related to the adult's inability to tolerate tension either in the mind or in the bladder (Ferenczi).

#### PHALLIC STAGE

This interval begins in the third year and extends to between the fifth and seventh years. During this stage the individual is aware of only one type of genital, the phallus. An awareness of the difference in the sexes was held to create a "castration anxiety" in boys and a "penis envy" in girls.

#### LATENCY PERIOD

During the pregenital stages, the restrictions that are continuously imposed by parents, as well as the love, affection, and attention which the parents provide, produce an ambivalent altering or division of the child's feelings. Competition for the mother's affection and attention, and jealousy over the particular status and prerogatives of the father in the family group, engender a rivalry and hostility toward this individual.

The boy early identifies with the father and wishes to be like him and later to replace him. Identification is ambivalent from the start and may vary from a feeling of tenderness to a desire to remove and replace, thereby making the identification complete.

According to the Oedipus myth, the father is slain by the son who then replaces him and takes the mother as a sexual object. The hostility toward the father and the possessiveness felt toward the mother during the early years of childhood produce such phantasies which Freud believed succumbed to repression and were followed by the *latency period*. The identification of the boy has with his father and the holding of the mother as a love-object continue for a time "without any mutual influence or interference"; with time they fuse and the "normal Oedipus complex originates from this confluence."

## PASSING OF THE OEDIPUS COMPLEX

Freud offered three possible reasons for the passing of the Oedipus complex

*First*, the complex may be extinguished because of a lack of success since the child who regards the mother as his property may find her affection transferred to a new arrival, or the impossibility of gratification and the continuing frustration may demand another solution

*Second*, the Oedipus complex may end at a time previously determined by heredity to make way for the next pre-ordained stage of development

*Third*, in the boy, after he has advanced to that point where the genital organ has taken over the 'leading part' in his sexuality—the phallic stage—he is aware of only one type of sexual organ (the one which he possesses), the phallus. However, he has previously given up the breast and has undergone toilet training which Freud held prepared him for the threat of a third loss or castration. He then discovers that there are two types of sexual organs, or rather that some have a sexual organ as he does, and others do not.

Since there are those otherwise like him who have no phallus, and since he may well have some idea of what constitutes 'love intercourse,' either by chance observation of the parents in action, or by information from older children, he presumes that such a relationship involves a loss of the penis. This possibility provokes a conflict between the narcissism with which the organ is endowed and the object libido directed towards the parents.

Normally, the narcissism triumphs and the child's ego turns away from Oedipus complex which succumbs to the threat of castration. This turning away from the Oedipus complex is an act of repression by the ego, the later repressions being reinforced by the superego which is only built up during this process.

The authority of the parents is introjected into the ego which becomes the 'kernel' or foundation of the superego. The super ego then 'takes its severity from the father, perpetuates his prohibition against incest,' and by so doing insured the ego against a recurrence of the threats of this particular libidinal object-cathexis. Ideally, this process is more than a repression and results

in a 'destruction and abrogation' of the Oedipus complex. If this destruction does not occur and the complex remains only repressed in the id, it may later become manifest with pathogenic effects.

The libido belonging to the Oedipus complex is desexualized or sublimated, inhibited in its aim, and altered to become affectionate feelings. As a result of these reactions, the genitals are preserved and the fear or danger of a loss of an organ is avoided but at the same time the function of the organ is taken away by the introduction of the *latency* period in the child's sexual development. This latency or arrest in sexual development persists until its interruption by the onset of puberty.

Normally, in the boy the early identification with the father continues, the father is literally what the boy wants *to be*. Along with this, a true object-cathexis of the anachitic type develops towards the mother. Subsequent object-choices following the onset of puberty are colored and in some degree based on these prototypes: the father and mother. Freud emphasized the importance of the resolution of this complex in the following statement:

'Every new arrival on this planet is faced by the task of mastering the Oedipus complex.' He added that a failure to do so would terminate in a neurotic state.

After puberty each individual is also faced with the problem of freeing himself from the parents. This process of gaining independence does not begin with puberty but only enters its final phase at this time. From the time of delivery, the separation from the mother must proceed in keeping with physical maturity if the child is to establish himself beyond the confines of the family group.

The order of the Oedipus complex may be inverted and the boy, instead of identifying with the father, takes him as an object, in this case the father is what the boy wants *to have* rather than what he wants *to be*. Freud explains the dynamics of a large class of male homosexuals as follows. The boy takes the mother as a sexual object until puberty, at which time she is abandoned as an object, but he identifies himself with her and remolds his ego upon the model of this previous sexual object which is then renounced. He subsequently seeks objects which can replace his ego and on

whom he can bestow the love and attention his mother has previously shown him.

Regarding the resolution of the Oedipus complex in the girl, Freud noted that the necessary insight into the dynamics was less complete, more shadowy, and unsatisfying. The girl was presumed to accept castration as an actual fact which removes this possibility as a threat and therefore as a motive for forming the superego and "breaking up the infantile genital organization." Consequently, in the girl the superego results more from educative influence or external intimidations threatening a loss of love. Too, the girl's attitude is seen as being less positive than that of the male and "seldom goes beyond a wish to take the mother's place, the feminine attitude towards the father." As compensation for the lost penis, the girl passes over by "symbolic analogy" to being given a child by the father.

Horney questions whether the sexual attraction for the parents, without other factors being included, is ever of sufficient intensity to meet Freud's concept of the Oedipus complex requiring repression. Masserman gives a concise account of Freud's "suppositions" as described in *Totem and Tabu* from which the primitive sources of "Oedipal guilt" are derived. Essentially, this "psycho-mythology" relates to a competition of the younger males with the father for dominance and possession of the women (the mother); a similar primitive contest between the females as an origin for the complex is not described.

This period of latency, which extends roughly from the fifth or seventh to the eleventh or twelfth year, is latent only in the sense that there is a relative lack of overt sexuality or functional development. The effects of the peer group on the child during this interval of latency, and of the importance of group status particularly in the years approaching puberty, should not be overlooked.

Sullivan stresses the effects of learning successful ways of expression and performance during this time, such learning being encouraged by everything from prestige with "one's fellows" to the anxiety created by direct, crude, and critical reaction of other juveniles. He also describes this as the time when the world begins to be really complicated by the presence of other people and a time

in which the ideas and behavior which were acceptable in childhood and at home have to be altered

### *Genital Stage*

With adolescence sexuality becomes less diffuse and is focused in the genital area. There is a somewhat sudden physical growth and change which are accompanied by equal demands for growth in the elements of the personality. The sexual impulses of the id previously diffused, desexualized and sublimated suddenly are markedly reinforced by the physical sexual maturity and are focused on the genital area.

The ego has to reckon with these internal forces and bring about their discharge in a manner acceptable to a superego which during latency was only vaguely if at all threatened with such problems. The opposite sex, little noticed during latency, assumes a new appearance and purpose. Since the sexual instincts have become localized in the genital area, normally another individual in phantasy or in fact is required for their gratification.

The ego, being first a body ego or a reflection of the stimuli arising from the body's surface, has the secondary sexual changes of maturity to reconcile and accept. They cannot be denied although such efforts may certainly be made as in the self-conscious girl who walks stoop-shouldered to decrease the prominence of her breasts or in the adolescent male whose interest and thoughts are not yet in keeping with his deep voice and increasingly mature appearance.

This transition from the dependency of childhood to the freedom and responsibility of being an adult is a battleground of ambivalence. There is a drive or urge to break openly with parental dominance, opposed by a fear of the isolation and responsibility for self which it entails. The adolescent vacillates between aggressive rebellion and a desire for the previous security of dependence.

The insecure adolescent may reassure himself and overcome some of his fears of independence by rebelling at home. The painful awareness of self may be denied by projecting the shortcoming to the parents whose inadequacies suddenly become glaringly ap-



parent, particularly before his friends. This projection bolsters the ego of the adolescent but may be somewhat disturbing to the parents.

A very attractive 15-year-old girl was seen because her criticism of the family had practically disrupted the household. The only member of the immediate family who was not a recipient of her criticism was an older brother, a physician.

Each day when she returned home from school she ran her finger over the furniture to see if it had been properly dusted. Each meal was a strain due to her revulsion at the table manners of the other members of the family. The event which led to her being seen was her asking the father if he would mind leaving his favorite chair and remaining in his room when her 'date' came after her because the father was so uncouth she preferred not to have to introduce him.

If the turmoil in the home is sufficient, the parent may retreat to solutions which were effective in previous years, but prohibitions, restrictions, warnings, and even threats are increased with little success. Even more disturbing to the parents is the adolescent's abrupt withdrawal of information about himself, since he is making new discoveries daily which his parents are too insensitive to appreciate, he becomes as inscrutable as he pictures himself to be. Consequently, the more questions he is asked, the briefer and less informative are his answers.

The physical changes in adolescence are no greater than the increased appreciation of self as the hours of rapt consideration before a mirror show. A walk or manner of speech may be affected as one personality after another is tried out on the family. A single pimple may destroy a day.

The richness of the adolescent's phantasy life may be most evident at meal time when his preoccupation is such that nothing less than a shout is sufficient to stimulate him to pass food to the others.

Time and age take on a new meaning. His interests become adult before his years; he must constantly wait until he is older to do what the present demands. A rather obvious conclusion is that the world is badly in need of change which the adolescent firmly resolves to effect as soon as he is a little older. This resolution spends itself on the increasing demands of reality, and whatever

residual persists is transmitted to his offspring, who undoubtedly will have more time.

A peer group, in which the adolescent can express his anger and frustration safely, and with whom the guilt and anxiety of his own superego can be shared, is essential. These forces which characterize adolescence are somewhat beyond solution by means of introspection; and lacking a group, he may be faced with the solution offered the "isolated neurotic," according to Freud's formulation. "If he is left to himself, a neurotic is obliged to replace by his own symptom formations, the great group formations from which he is excluded. He creates his own world of imagination for himself, his own religion, his own system of delusions, and thus recapitulates the institutions of humanity in a distorted way."

### MENTAL MECHANISMS

In order to remain homeostatic, or to keep his inner and outer demands in balance, an individual's ego utilizes what has been described as *mental mechanisms*. These mechanisms make complex adjustments possible and ideally allow one to safely gratify his needs without censure from his superego on the one hand, or society on the other.

It must be emphasized that these mechanisms are active in the well as in the ill, and that the utilization and exaggeration of a particular mechanism to maintain an unstable balance is characteristic of many psychiatric syndromes. Whenever irritation cannot be adequately discharged and accumulated, or when external stimulation is excessive and cannot be avoided or relieved, a state of increasing tension or a conflict results.

Generally, a conflict of recent origin in a previously adjusted individual is of external origin, whereas those of a more prolonged or chronic nature arise within. Regardless of the origin, the tension produced by an emotional conflict is discharged by the utilization of one or more of the mental mechanisms.

#### *Repression*

As an individual evolves a concept of himself, he denies impulses or ideas which are intolerable to this concept. If this concept is unrealistically rigid, thoughts which threaten the integrity or coherent

function of the ego are unconsciously repressed. This repression avoids anxiety by preventing the denied impulse from reaching awareness.

Repression has been called the cornerstone of dynamic psychiatry. The making conscious of repressed ideas or impulses frees the energy repression requires and allows the individual to be more spontaneous.

Freud states that ideas inimical to the ego or those that threatened the self-respect of the ego were repressed. Breuer termed such ideas or complexes of ideas "inadmissible" to conscience. Repression occurs unconsciously, and by keeping the intolerable from awareness the individual is spared the discomfort of anxiety and the need to reassure himself constantly as to what type of individual he is.

### *Sublimation*

An instinct may be altered in its object and in its goal and discharged in some manner acceptable to the ego and society. Instincts may be desexualized and gain expression as affection; and aggression and hostility may be discharged in a manner that will lead to gain for the ego (in competition, as in sports). Consequently, an unacceptable instinct, though repressed, may gain expression in a manner that is both acceptable to the individual and society.

### *Conscious Control*

The ego may accept the existence of desires and impulses, the expression of which would be hazardous; the individual may then exercise conscious control of his behavior and seek the methods of substitutive satisfaction that his group allows. This conscious awareness of motivation allows behavior to relate to external circumstance rather than inner denial and frees the energy required for repression for use in a productive manner.

### *Rationalization*

Following an act which was in some way disturbing and which resulted from unconscious motivation, the ego may recapture lost esteem by constructing intellectual reasons for the behavior. The

reasons are acceptable to the conscience, of the individual and serve to further conceal and deny the unconscious and less lofty motivations

Similarly, the ego threatened by undeniable evidence of failure, ignores the obvious by providing reasons beyond self for the inadequacy. These reasons may vary from exaggerating the forces that caused the failure, to minimizing the importance of the loss \*

Therefore, this much utilized "rational" approach to contradictory behavior or failure attempts to justify shame-producing activity without a loss of self respect. This may be accomplished by forming intellectually acceptable reasons, by attributing failure to external odds rather than inability, and by depreciating and minimizing the importance of the loss itself

### *Compensation*

An individual may attempt to conceal a real or imagined deficit by an exaggeration of some other characteristic or ability, thereby covering the weakness or compensating for the lack. Usually the compensation requires either the approval or envy of others to aid the ego in being reassured. Efforts at compensation balanced by ability are found in many productive people, this overcoming of a handicap is a frequent motivation in the successful

However, there are many who cannot wait for eventual recognition on the basis of tediously gained excellence, instead they attempt endlessly to gain momentary prestige by differing from their group through extremes or by merely demanding attention. Such reassurance as this short lived attention offers may be followed by rejection and the individual soon has to repeat the performance (not infrequently before a different group)

### *Reaction Formation*

This is the development of a character trait (or habitual manner of responding) which is the opposite of the unconscious wish or impulse. This trait consciously aids the individual in avoiding the unconscious wish. The greater the denied impulse, the more marked

\* Medical rationalization sounds like this "I didn't miss the diagnosis it was just more obvious when the next doctor examined the patient"

the reaction formation would need to be. As Jung pointed out, the existence of extremes of behavior always leads one to suspect the opposite, and those who make too great an issue of their virtues may reveal how formidable temptation has become.

Similarly, those so considerate of others as to encourage imposition, may nevertheless bear the usual amount of hostility and resentment which is concealed behind a passive acceptance until it escapes in a bout of acute anxiety.

### *Projection*

This is the mechanism by which intolerable qualities (aggression, guilt, desire, or hate) existing unconsciously within an individual are attributed to another. These qualities are then free to be criticized and even more strongly denied. This mechanism is further enforced by the fact that anger toward another is less disturbing than depression or anger directed at self.

The degree to which projection occurs depends on how great the threat to the ego by the unconscious impulse and the amount of fear, aggression or guilt that has to be dealt with. This is seen in a mild form in the department head who overstays his vacation and immediately insists everyone must work harder and get more done, at least until his guilt subsides. At the other extreme is the paranoid with an organized system of delusions to whom nothing that occurs is impersonal, and all that is perceived is directed towards him in a derogatory or threatening manner.

### *Introjection*

Introjection is a term introduced by Ferenczi and is related to the primitive mechanism of incorporation. The psychical assimilation of pleasurable experiences early in life and their inclusion in the ego is introjection. It is the opposite of projection.\*

### *Identification*

This is the means whereby the qualities and attitudes of others are unconsciously made part of one's own ego. This begins early

\* Ferenczi states "I called the first phase of all, in which the ego alone exists and includes in itself the whole world of experience, the period of introjection." This he differentiates from the second phase in which omnipotence is ascribed to external powers, this second phase he termed "the period of projection."

with identification with parents, with those in authority and with those the individual desires to be like. A second type of identification results when one endows a new acquaintance with the qualities and affect of a person previously known.

### *Regression*

When a conflict arises of such a complicated or overwhelming nature that previously successful types of adjustment fail, the individual does not evolve more complex forms of behavior, but reverts to a more simple and previously successful level in an attempt at a solution. This is regression.\*

The most extreme instance of regression is seen in the schizophrenic who forgoes all responsibility for self and assumes a withdrawn, infantile attitude which requires that someone care for him totally. In such extremes, the patient's behavior does not vary greatly from that of an infant except for his lack of activity and a failure to show evidence of a desire to have his needs fulfilled.

### *Symbolization*

In order to communicate, objects are represented vocally by sounds or usually by written words, which in turn become the symbol of the object. Not only do these symbols represent the object as it is perceived, but they also carry the affect or feelings with which the perception is endowed. The transfer of the affect which the object originally assumed to its symbol is the process of symbolization.

A symbol may be endowed with conscious or unconscious meaning and may be utilized to gratify safely desires which could not be directly expressed. An inanimate object may become a symbol for the feeling of kinship of a group, as the totem in primitive cultures; such a symbol may be endowed with great powers and in-

\* Regression may be evident from a mild to an extreme degree. As an example, an individual does not receive a promotion which he believes he merits in his employment, and necessity requires that he continue to work. He may refuse to listen or believe any explanation offered for not being promoted. He may become irritable, petulant, querulous, or destructive and show his ill will, as a child who merely seeks an avenue to vent his anger without the purpose of solving the problem or of avoiding a future similar occurrence. On the other hand, he may assume a "wounded or hurt" and dependent attitude much as he did earlier in life with his parents when overwhelmed by any event or faced with a loss of security.

fluence. Although in the present culture totem poles are less than common, an occasional "rabbit's foot" appears on the end of a key chain or a particular coin is carried with no other purpose than to exert a symbolic barrier against the vagaries of fate or "bad luck."

In treatment, symbolization may be of importance due to the negative connotation the symbol may assume; the meaning of such symbols must be clarified to bring understanding to the patient's conflicts. For instance, marriage may not be a ritual performed according to the demands of the culture, but instead may symbolize all of the insecurity, threats, and deprivation to which the patient was subjected in childhood.

### *Displacement*

Affect or anxiety may be transferred from one situation, object, or person to another more acceptable substitute. This process is termed displacement. It occurs frequently in the anxious and provides a safe means of discharge of tension. Subsequently the anxiety is related to a particular situation, person, or object which the patient can consciously guard against.

This mechanism is shown in phobic reactions in which sharp objects or particular situations provoke anxiety displaced from unconscious sources. This mechanism acts to assure the coherent functioning of the ego by circumscribing the anxiety-provoking situation which the ego in turn attempts to avoid. A similar mechanism is operative in compulsive rituals in which "hand-washing" or avoidance behavior attempts to vitiate or relieve the anxiety displaced from within. Also, the affects or anxiety associated with one individual may be displaced to another.

### *Dissociation*

In some individuals ideas or behavior which are not tolerable to the ego are denied consciously and are "split off" from the memory of the patient. This unacceptable behavior is then dissociated and exists as an unseen and unknown island in the personality. It is as though the individual has two personalities which lead separate existences and are unaware of each other.

The dissociation may be manifest as a fugue state in which there may be disturbances of consciousness as well as amnesia and an actual physical flight from the immediate environment. A dissociative amnesia may occur, and the more successful and complete the dissociation the less concern the patient will show over the memory loss. These reactions are typically found in hysterical patients.

### *Conversion*

This mechanism which is seen in the hysterical individual results in the unconscious change (or conversion) of anxiety into a symptom with a function loss involving either voluntary musculature or a special sensory organ system. The more complete this conversion is the less the anxiety and the greater the indifference to the symptom.



## 4

# *PSYCHIATRIC EXAMINATION*

Introduction

Procedure in Taking Psychiatric History

Chief Complaint (Presenting Problem)

Present Illness

Past History

Mental Status Examination

Appearance and General Behavior

Stream of Talk

Mood or Affect

Thought . Content and Special Preoccupations

Sensorium

Memory

General Information and Intelligence

Insight and Judgment

Evaluating the *Uncooperative Patient*

Premorbid Personality

Psychodynamic Formulation

## *Psychiatric Examination*

## INTRODUCTION

The psychiatric examination should reveal the nature, course and chronicity of the patient's illness. This examination includes the chief complaint, the present and past history, the mental status, a psychodynamic formulation, and a diagnosis. The examination should first establish whether or not the patient is ill. If he is ill, the beginnings of his illness as well as his symptoms should be clarified, his abilities should not be ignored in a total emphasis on his problems.

Besides clarifying the type, duration, and course of the patient's difficulty for the interviewer, the psychiatric examination should reveal the data on which the diagnosis is based. Ideally, the patient should be recognizable from what is written, but too frequently the most identifying information in the record is the patient's sex and age\*.

Not only should significant factors in the history be noted, but their relevance to the development of the present illness should

\* The descriptions offered nonprofessionally of other people are often much more vivid than the stylized, inanimate outlines found in many histories. For instance in a record this was written: "The patient is a neat appearing, well nourished male of 40 of average height. When the resident was reminded this description fit a rather large segment of the population including the staff, he replied "All right he's a pale little man who combs his hair straight back, wears sharp-toed shoes and smells like a barber shop." On rounds, everyone recognized the patient on sight and smell.

be made clear. The history is not a collection of isolated events but a record of the distinct course the patient has followed which culminated in his being seen for treatment. The findings on the physical and neurological examination are also recorded.

When information is obtained from others about the patient, the source should be stated (referring physician, relative or friend, or other); it should also be indicated whether the information is based on observations or interpretations. Similarly the interviewer's interpretations should be clearly differentiated from the historical data, to permit others reading the record to form their own conclusions.

The patient must be observed; he must be continuously in the examiner's field of awareness. Where feasible, the patient's own words should be quoted since they will be much more descriptive than the observer's interpretation.

### PROCEDURE IN TAKING PSYCHIATRIC HISTORY

The method of obtaining the history will depend on the patient's attitude, his insight and willingness to cooperate, and the clarity of his sensorium.

Every effort must be made to put the patient at ease and to encourage him to state his opinions. He should be allowed to give his impression of his difficulty and what he believes the causes to be. The details should be filled in later and compared with the record obtained from other persons. Precipitating events, the type of onset, and when the patient last considered himself to be well should be established.

Tact and consideration must be used. Disturbing questions should be dropped and approached later when the patient is more at ease. If the patient has just been admitted he may feel confused, perplexed, and threatened by the hospital routine. He may have been coerced or deceived into accepting treatment, and he may have justifiable grounds for his suspicions about the examiner.\*

\* This was well illustrated by a patient who seemed more apprehensive with every attempt to be tactful. He was asked what was frightening him. He immediately replied that less than an hour earlier, four doctors had talked "real nice" to the patient in the room with him, and then they grabbed him and carried him off. He was quite correct. The other patient had been somewhat reluctant to have his somatic treatment, and, all efforts at persuasion having failed, he was literally carried from the room.

### *Chief Complaint (Presenting Problem)*

The factors that lead to the patient's seeking treatment or being hospitalized are described. This should be based on the patient's explanation and should include a verbatim statement of his impression of the problem.

### *The Present Illness*

The patient's description of the presenting problem allows the examiner to proceed directly to the events (both external and internal) which culminated in the existing symptoms. The conflicts which may have produced them and the patient's efforts to solve his problems are clarified. These factors are established as rapidly as they can be comfortably related by the patient.

The order in which the data is obtained depends on the patient's ability to discuss the events he considers significant. However, once the material is obtained it should be recorded in a concise sequential fashion according to the chronological order of occurrence.

Any previous psychiatric illness with the date, nature, duration and treatment should be recorded. The previous medical history is similarly noted. It is not sufficient merely to state that the patient had brucellosis or influenza; it must also be established whether the patient responded to treatment and particularly how long he was incapacitated by the illness.

It is not unusual to find a patient who gives no history of a previous psychiatric illness but who was ill at home for eight or nine months with a relatively minor medical disorder. Events which preceded the somatic illness as well as the patient's mood and activities during a prolonged incapacity with some vague complaint needs to be clarified.\*

\* An engineer seen after an episode of acute anxiety which he believed to be a heart attack, denied any previous similar illness. But 5 years earlier he had been ill for three months with diarrhea and vomiting which was diagnosed first as an "irritable colon" and later as amoebiasis, although he responded to treatment for neither condition. He was too ill to continue his work and changed jobs.

During his sophomore year in college he had developed severe headaches which finally led to his dropping out of school and spending seven months at home. He had been thoroughly studied for these headaches which were first attributed to astigmatism and later to a chronic frontal sinusitis. In both of these previous episodes the symptoms were atypical and failed to respond to the usual therapeutic measures.

### *Past History*

When information is taken from someone other than the patient, the informant's relationship to the patient and a brief description of the interviewer's impression of the individual giving the information should be included.

#### FAMILY HISTORY

The facts regarding the family, past and present, should be given first (that is, who was in the home, members of the family, number of siblings, etc.) The type of home, the relationship of the patient to the other members, the dominant person in the family, and other individuals significant to the patient should be described.

The interviewer should get as complete a picture as possible of the relationships within the family, and the extrafamilial patterns as well. Too, the nature of the values, aspirations, and drives existing in the family should be ascertained.

The occurrence of a similar difficulty in any other member should be determined. In using the term "nervous breakdown" the laity may refer to anything from acute anxiety to psychotic turmoil. Therefore, the symptoms, treatment, and duration of any mental illness in the family should be obtained. If another relative is described as "nervous," this should be explained.

The insight gained from interviewing several members of the family allows a more valid determination of how much of the patient's behavior is individual and how much is a reflection of a family pattern. This is especially desirable if the family is from a different culture or country.

#### PERSONAL HISTORY

The stages of the patient's early development should be described in chronological order. The existence of adjustment reactions, habit disturbances, or neurotic traits in childhood should be checked. The patient's adjustment outside the home, in play and at school, and any change that may have occurred in his relationship with his peer group should be specifically clarified.

If the patient quit school or failed a grade, the circumstances prevailing in his life at the time should be explored. Did the pa

tient have the same advantages as others in the school he attended? Was he dressed differently or teased or ridiculed? Was he "pushed" excessively by his parents?

The occupational history should be similarly noted; the reason for job changes should take precedence over the fact that they occurred. Some of the questions which might be asked are: At what age did he first hold a job? What kind of work? Did he enjoy the job? Any trouble with other workers or employer? How long employed at last job? Military service: duration, rank, type of duty court martial, type of discharge, and pension?

The social history may be logically followed by a discussion of the patient's sexual history. Was he part of a group as an adolescent? When did he begin to date? At what age was he married?

This information gives the interviewer insight into the patient's ability to form casual, superficial, or group relationships. It follows that a patient who was uncomfortable merely being with others may have found the intimate relationship which sexual intercourse ordinarily demands extremely difficult.

It also follows that a reticent patient may have difficulty relating his sexual history. Therefore, questions regarding masturbation or heterosexual and homosexual experiences should be discussed at the appropriate time (that is, when the patient is able to do so).

It is of the greatest importance for the examiner not to "lead the interview" nor to show more interest in completing a form than in listening to the patient. The history should reveal those events in the patient's life which he feels are significant.

## MENTAL STATUS EXAMINATION

Much of the mental status examination should become evident as the patient gives his history, and should be noted as the interview proceeds. Too, an awareness of the patient's "appearance and behavior" begins from the moment he enters the room—his bearing, his walk, his expression, his hand-shake are much more indicative of his mood or preoccupation than a studied reply to a routine question. The following should be considered in evaluating the mental status:

### 1. Appearance and behavior

2. Stream of talk
3. Mood or affect
4. Thought content and special preoccupations
5. Sensorium
6. Memory
7. General information and intelligence
8. Insight and judgment

### *Appearance and General Behavior*

Any abnormalities of dress or appearance, any mannerisms, grimacing, or tics should be recorded. The patient's activity when first observed (pacing, overactive, or underactive), and whether he came to the interview readily, reluctantly, or without interest, should be noted. Are his movements spontaneous or does he show stereotyped activity or slowness of response?

### *Stream of Talk*

Output: Is the patient's speech rapid, slow, excessive, or does he refuse to answer? Is the speech coherent, is it circumstantial, is the patient unable to clarify his thoughts? Is he distractible, is there a "flight of ideas" from one topic to another? Is there a slowing of psychomotor activity?

Are the associations appropriate to the topic, does he attempt to communicate or does he ramble on unaware of the interviewer, and unaffected by the external environment? Several samples of the patient's speech should be given verbatim, preferably as he replies to a stated question.

### *Mood or Affect*

Does the patient appear elated, depressed, irritable, perplexed, or suspicious? He should be asked, "How do you feel?" "Are you happy?" and "Are you sad?" and his answers recorded. How labile is his mood? Does the mere asking of the question appear to alter the patient's emotional state?

Do the patient's answers fit his expressions; does his smile reflect his mood or is it mechanical and forced? Is the mood appropriate to the thought, is the mood alterable or does it "stick" to preceding



thoughts? Is there any change in the patient's mood during the interview?

### *Thought Content and Special Preoccupations*

The patient's special preoccupation his hallucinatory experiences and his delusional beliefs are sometimes not immediately obvious to the examiner. The patient must be closely observed not only when he is questioned but throughout the interview to judge accurately the existence and force of the hallucinations or delusions.

Hallucinations (perception arising without apparent stimulation) may involve any of the special senses. Auditory hallucinations or the voices are the most frequent. The patient may be asked if he hears the voices; he may reply, "I hear your voice." Not now, or Sometimes. He should be observed to see if he blocks his eyes, fixes his gaze and assumes a listening and attentive attitude. It should also be noted if he talks or argues with himself when no one else is near him.

The voices are usually accusatory and unpleasant; the content and the reality value to the patient are of importance. Other hallucinations may involve bad tastes or disagreeable odors; hallucinations of sight and touch may also be experienced.

Illusions are misinterpretations of perceptions; they are frequently found in toxic states. In delirium the illusions are usually frightening or threatening to the patient.

Delusions are illogical ideas which are contrary to the beliefs of the individual's group; these ideas are not changed by logical argument. They are most frequently of a persecutory nature; they may also be grandiose or belittling. In depressed states the patient may consider himself persecuted but guilty. The delusion may be evolved from a fragment of fact and may be sufficiently isolated to allow the patient to carry on many activities.

Evasive or circumstantial answers to impersonal questions may indicate undue suspicion or delusions which the patient is attempting to conceal. A patient who weighs each answer he gives as though the interviewer had some unrevealed meaning in the question should cause the interviewer to delay his conclusions until

the reason for lack of spontaneity is evident. In some patients each move, each gesture, or each question the interviewer asks may be immediately included in a delusional system. For instance

When asked what led to her being hospitalized, a patient replied with a smile, 'You already know

'How do I know

I saw you outside the window, the patient replied with that unruffled conviction that makes denial a waste of time

I'm afraid you're mistaken. I wasn't outside the window (without half the patient's certainty)

I knew you'd say that, was the smiling answer

### *Sensorium*

The patient's orientation as to time, place, and person should be evident as the interview progresses. Since direct questions regarding orientation may be irritating and may be resented by the patient, if possible they should be tactfully concealed in the routine of obtaining the past history. Evasive or only partially correct answers, particularly from the aged, should make one suspicious. If this doubt continues, then direct questions must be asked: What day, month, and year is it? What is this town and building and who am I?

### *Memory*

The recent and remote memory should be checked by questioning the patient about his recent activities (what he had for breakfast, his address, etc.), and about remote events, these in turn should be checked with his relatives.

### *General Information and Intelligence*

The patient may be asked the names of prominent persons—the governor or the President—and other facts with which he should be familiar—the three largest cities in the country, for example. He may be asked to do serial sevens (subtracting seven from a hundred, seven from the result, and so on).

Discrepancies between the patient's background and his achievement should prompt one to more questions or to psychological testing. The patient's answers must also be evaluated to determine

whether he is attentive and makes an effort to answer. It should be recalled that the anergic, preoccupied schizophrenic may appear defective merely because he does not respond.

### *Insight and Judgment*

Does the patient accept the fact that he is ill? He may have insight into the fact that something is wrong but may misinterpret the cause. His judgment may be further determined in part by his attitude toward his illness or his plans following discharge if hospitalized.

### *Evaluating the Uncooperative Patient*

If the patient is negativistic, belligerent, or uncooperative, several visits may be required to complete the evaluation. When the patient becomes agitated or uncooperative further questioning should be delayed until a later time. Such patients should be closely observed for evidence of dehydration and malnutrition during turmoil states. A short acting barbiturate given intravenously or intramuscularly may decrease the turmoil and permit the patient to verbalize more adequately.

## **PREMORBID PERSONALITY**

The history should reveal the type of individual the patient was before the illness. How mature was the patient? Did he assume increasing responsibility for himself and others from adolescence until the illness became manifest? Was he motivated from within or did he merely respond to pressures from his parents to attend school or eventually to go to work? As an adult did he noticeably lag behind others in his age group in his interests, activities, and energy output? At what age and in what circumstance did he seemingly make his most adequate adjustment?

Was he moody without apparent cause? Was he cheerful and happy, or pessimistic? Did he prefer to be with others or was he more comfortable alone? What seemed to give him pleasure and what did he attempt to avoid? What characterized his behavior and how did his premorbid state compare with his appearance in the interview?

*Psychodynamic Formulation*

This is a concise summary of the case, including the present problem, the pertinent factors from the history, and an evaluation of the mental status. From this summary an impression of the dynamic factors considered to be of etiological significance may be drawn, and suggestions for treatment offered. The patient is then diagnosed according to the standard nomenclature.

## 5

# *PSYCHONEUROTIC REACTION TYPES*

Anxiety Reaction

    Clinical Description

        Onset

        Physical Symptoms

        Psychic Symptoms

        Course

Phobic Reactions and Obsessive Compulsive Reactions

    Phobic Reactions

    Obsessive Compulsive Reactions

Depressive Reaction

Conversion Reaction

    Characteristics of a Conversion Symptom

Dissociative Reaction

## *Psychoneurotic Reaction Types*

*'Fear walks up and down the jungle by day and by night'* —RUDYARD KIPLING

Anxiety may be defined as a state of morbid apprehension or dread over anticipated ills accompanied by autonomic dysfunction. The psychoneurotic reaction types are the means by which the patient attempts unsuccessfully to control his anxiety.

### ANXIETY REACTION

In an *anxiety reaction* (that is, anxiety tension state, acute anxiety) the patient is in a state of unpleasant or painful apprehension over anticipated difficulties, he is in a state of 'dread,' of undue and illogical concern, accompanied by a morbid awareness of self. There is fear without apparent cause, a response to a concealed or unknown danger which keeps the individual in a condition of mental and autonomic preparation to escape from (or attack) some hidden threat.

Actually, the individual's ego is threatened by the pressure from repressed material. The nature of the repressed ideas or impulses varies with the patient, but they are intolerable to the ego and the individual's concept of himself. Their expression or escape into awareness being intolerable, would be overwhelming to the coherent functioning of the individual, and the integrated contact his ego maintains with reality.

The acute episodes are seen as sudden discharges of this repressed energy accompanied by an increased autonomic response. The very control the patient attempts to exert over his behavior

to conceal this inner turmoil only serves to block further the release of the pent up drives and tension which eventually accumulate sufficiently to produce another episode. The patient may date the onset of his discomfort from the time of an acute beginning, but usually a period of several weeks of increasing tension preceded the episode of panic.

In an anxiety reaction the symptoms do not control the anxiety and the patient is extremely uncomfortable, he walks the thin edge of panic and attempts, with great effort, to conceal his tension. A subjective division may exist in his symptoms as far as the patient is concerned. He is likely to attribute somatic symptoms to a physical cause and the psychic ones to his mental state. The difficulties the patient may face in communicating his unpleasant subjective experiences must always be kept in mind. Therefore, for descriptive clarity the complaints will be grouped under physical and psychic symptoms.

### *Clinical Description*

#### ONSET

The onset of an anxiety reaction may be with an episode of intense fear or panic accompanied by marked autonomic dysfunction. The episode may begin suddenly without apparent cause or warning, with palpitation, tachycardia, vertigo and generalized perspiration. The individual may be in a confining situation from which he has an overwhelming urge to escape, in extreme situations he may dash out of a theatre or church, or leap from a barber's chair half shaved. He may be convinced he is dying, losing his mind or having a 'heart attack'.

The physical activity he performs seeking relief, the focusing of his attention and efforts on the immediate problem of finding help, decreases his tension and he is shortly less distressed but no less concerned. If a patient is seen following an acute episode he may minimize his recent discomfort, not because he is less frightened but for fear the doubts about himself may be confirmed by his physician. Following the acute phase the patient may have a continuing autonomic disturbance producing symptoms in many areas of autonomic innervation.



## PHYSICAL SYMPTOMS

The most obvious and least described finding in the anxious patient is the regularity with which normally unconscious autonomic functions and somatic sensations intrude upon awareness

This physical awareness of self and dysfunction proceeding from the head caudally are as follows. He may be unable to hold a focus while reading the letters blur, and he fears his sight is failing or his eyes may feel irritated and "burn"

Headache, usually occipital and extending downward between the shoulders as the day wears on, is a frequent complaint. In others the headache may exist as a feeling of pressure which may be experienced as a tightness of scalp, or a feeling of constriction around the head and over the eyes ( hat band headache ) or a sensation of internal pressure or fullness. There may be a numbness or increased sensitivity of the scalp. His mouth may feel dry, his tongue may feel thick, and he may feel like weeping.

He may develop a "lump" or constriction in his throat and have trouble swallowing, fearing that he may choke. His appetite is retained, but his taste is blunted and he no longer enjoys a meal as he previously did. Insomnia may be particularly troublesome and the lack of sleep may increase his fear of becoming debilitated and developing some organic illness. Since sleep is hardly a voluntary function, the more concerned he is over his sleeplessness the more wide awake he becomes.

He worries over his respiration, feels short of breath and does not feel satisfied when he breathes. It seems he is not getting enough air. He becomes intermittently aware of his heart beat, has a vague discomfort or ache over his left chest, and may have to check his pulse repeatedly to reassure himself that it has not become irregular or weak. He may curtail his physical activities in a vain attempt to prevent cardiac palpitation.

Following a meal, his abdomen feels distended and full, his clothes are tight and uncomfortable, and he wonders if he has an ulcer. He may develop a diarrhea and fear this is the first evidence of cancer involving the gastrointestinal tract. There may be a urinary frequency with concern over kidney disease or diabetes.

There is usually an excessive amount of perspiration of the

palms of the hands and the feet, which may at the same time feel cold to the patient and to the examiner's touch. The patient is plagued with a fatigue which is not relieved by rest; he is exhausted and yet unable to relax as he may have been repeatedly advised to do.

#### PSYCHIC SYMPTOMS

In addition to the previously described somatic discomfort, the patient has an abiding concern over his own mental stability which is usually more distressing than his physical complaints. This concern arises primarily from his unexplained apprehension and dread. Being in a constant state of anticipation he is acutely and morbidly aware of himself and seeks endlessly after a cause for his fear.

When in crowds he may feel panicky and smothered, and when alone he may worry for fear he will "lose control" of himself and there will be no one to restrain or aid him. Crossing streets he may feel "faint" and weak and wonder if he can successfully cross to the other side or be able to avoid passing cars. It must be appreciated that his loss of self-confidence effects all his decisions.

#### COURSE

The course of an anxiety reaction depends on the premorbid adjustment and emotional stability of the patient, the degree and duration of precipitating factors and the severity of the reaction itself. If the etiology of the symptoms is appreciated and the cause rather than the complaints are treated, the prognosis is good for any given episode. The patient may date the onset of his discomfort from the time of an acute episode, but usually a period of several weeks of increasing tension preceded the episode of panic.

A 36-year-old housewife complains of insomnia, "nerves," and the fact she "cries all the time." She dated the difficulty from the time of a visit to the beauty parlor a week earlier. She was having her hair dried when she suddenly became extremely apprehensive.

"I didn't know what was happening, my heart was pounding and felt like it was going to stop. I couldn't breathe, I felt all choked up and I had to get out of there. I felt weak and I knew if you had a heart

attack you're supposed to stay still, but it was all I could do to keep from running out on the street.

'I told the beauty parlor operator I thought I was dying. I guess I scared her half to death. I stayed as quiet as I could, and they got a doctor somewhere. He listened to my heart and told me I was all right, it was just 'nerves'.

'Imagine me 'nervous'. I've never had a nerve in my body. What could cause me to be nervous? I'm on edge all the time now, and I keep thinking about myself. I just can't get comfortable, something is always worrying me.'

### PHOBIC REACTIONS AND OBSESSIVE COMPULSIVE REACTIONS

These reactions occur in patients who have a history of being overly conscientious, orderly, meticulous and rigid in their pattern of living. Unusual stress or a disruption of this pattern tends to make them hesitant, indecisive, vacillatory and ambivalent.

The orderliness functions as a planned defense against anxiety and prevents the occurrence of behavior which may be spontaneous or uncontrolled and therefore anxiety producing. These patients have rather fixed or rigid concepts of themselves, of what they may or may not do or say, and how they should respond. They may have a great deal of trouble expressing hostility or discharging emotional tension and, having this difficulty, they attempt to avoid tension by being orderly, precise, and well controlled.

Too, they are unduly concerned over the consequence of their behavior and of the retaliation an expression or revelation of their hostility may provoke. Unfortunately their behavior is more easily organized and controlled than their thinking and their conscious resentment when angry may demand even greater orderliness to conceal their hostility and prevent its erupting and being expressed directly.

#### *Phobic Reactions*

These reactions are fairly frequently seen and have been reported in as high as 20 per cent of a group of college students. Later these reactions disappeared spontaneously. They also occur twice

as frequently in women as in men. It is likely that only the more severe reactions are seen for treatment.

In a phobic reaction the patient has intense and persistent fears related to some specific situation, object, or idea. The fear in a phobic reaction results from anxiety which existed before the phobia developed. The pre existing anxiety which was of unknown origin and against which the patient consequently could erect no defense is displaced to a particular situation, object or idea with which he can cope consciously.

In a phobic reaction the individual is able to agree intellectually that the fears are illogical and without any basis in fact (which helps differentiate it from a delusion). Although he has intellectual insight into the absurdity of his concern, emotionally he continues to respond to the situation as though it were a real danger and experiences fear or intense anxiety whenever he is confronted with the phobic situation.

Since the patient in agreement that his fear is illogical and that there is no good reason for it to exist (but at the same time it is undeniably real), the anxiety must arise beyond his awareness or from the unconscious. The phobia must fulfill certain criteria if it is to aid the individual in controlling his anxiety. (1) It must be related to a situation or activity that he can consciously avoid (a man fears he may jump overboard on a ship, so he locks himself in his cabin). (2) It must be sufficiently foreign to the patient's personality to control the unconsciously arising anxiety (the overly protective mother fears she will harm her child, which is the most unlikely and at the same time the most disturbing act that she can conceive of herself doing).

Since the patient does not wilfully create the phobia, he cannot voluntarily rid himself of it. Phobias include fear of disease, of high places, of closed places, and other situations in which the patient feels threatened or unprotected.

A 48-year-old cook was seen in a state of great agitation. He was possessed with the idea he might put poison in the food he was preparing. He had had the idea intermittently for the past week and it was becoming increasingly difficult for him to go to work.

He had finished eight grades in school, with some difficulty. Previous

to the development of the fear he had enjoyed his work. He was married to an obese matronly woman and when asked about his wife he replied "She's all right but she's always kinda hangin' on to me."

He then revealed he had been having a rather hasty affair with one of the waitresses where he worked. It was difficult to determine whether he was most concerned with the guilt over the affair or the fear of apprehension by his wife, the waitress, husband, or his employer.

Attempts to obtain a history were frequently interrupted by the patient's plaintive question: "Doc, do you think I'll poison 'em?" On each occasion of his interrupting, he was reassured that he would not poison the customers. Then he said: "Doc, do you think that woman's causing this?" He was told the guilt and worry over the affair could very well be causing his trouble. "Well, to hell with her," he replied, "got to go to work. Doc, see you tomorrow."

The following day he returned as was his wont without an appointment but with the same question: "Doc, you sure I won't poison 'em?"

"I'm quite sure you won't, George. I hope you're right, Doc," and he was gone.

George was never seen again. He came back on two occasions but since he did not have an appointment and couldn't wait, he explained to the secretary: "Tell Doc I'll call him if I need him. I gotta get to work. I always knew when George had been there because his cigar had a distinctive quality that lingered."

During the next three years at widely separated intervals, once at 3:30 in the morning, the phone would ring and the immediate question was: "Doc, you sure I won't do it?"

"I'm sure you won't, George."

Okay, just wanted to be sure. There would be a click.

The first time he had a recurrence he had gotten involved with a woman away from his work, hoping this would permit him to avoid the fear. Once he called me back to be sure I remembered him, as he said: "You sure you got the right George?" I told him I was quite sure because I could smell his cigar over the phone. This apparently satisfied him because he hung up.

### *Obsessive Compulsive Reactions*

These reactions are similar to phobic reactions but less common, more severe, and more likely to become chronic. The individual does not feel free to control his own behavior; he is compelled to do, or to think, or to omit, and if he does not follow the compul-

sions he experiences marked anxiety and apprehension. In these patients the thoughts and acts control the anxiety by association (that is, the anxiety is associated with the disturbing idea or briefly relieved by the ritual).

Obsessional ideas are apparently derivatives of forbidden or intolerable impulses. If the impulse as well as the idea persists in a disguised form, then compulsive acts accompany the obsessive thinking. An increasingly involved system may be necessary to avoid the obsessive idea until all the patient's waking time is spent in nonproductive avoidance behavior; consequently, he may be totally incapacitated by this illness. Ritual may replace taboo; hand washing replaces the urge or compulsion "not to touch" or to avoid touching.

The hand washing ritual is one of the more common compulsive acts; in some it apparently is an attempt to wash away the wrong or to "undo" guilt. Such activities as counting, walking along a certain route, and avoiding or repeating certain acts are typical. These patients are characterized by orderliness, frugality, and obstinacy.

In others undue concern or obsessive fears that misfortune or an accident may have occurred to a member of the family may display evidence of an underlying hostility. This excessive concern may interfere with the happiness and life of those about whom they express the most worry (as in the mother who calls so often to check on the daughter's safety and well being that she prevents her holding a job). Sullivan emphasized the degree to which such people may control the behavior of others as well as themselves with their ritualistic activity.

These people tend to lead systematized, deliberate, premeditated lives in which great effort is made to avoid the spontaneous and the unexpected. They may be unduly preoccupied with time, have numerous clocks one of which they check against the other, and arrange all their waking hours according to an exacting schedule.

In some instances, at the onset of a depressive reaction a patient may complain of obsessive ideas and an urge to compulsive behavior; the recent origin of the difficulty and the previous person-

ality pattern aid in differentiating an ensuing depression from an obsessive compulsive reaction

The degree of incapacity the misery such an illness imposes can not be exaggerated

This patient was a 42 year-old female a college graduate and a mother of three who was active socially and civically and gave no superficial evidence of anxiety or tension She was of superior intelligence and during the first interview appeared to be totally composed and pleasant she smilingly stated she had been bothered by obsessive ideas which she knew were foolish and of which she would like to rid herself She had been previously treated for a brief period without improvement

During subsequent interviews the patient continued to be totally composed immaculate self-contained and was so precise that it was difficult to relax in her presence For years first intermittently and then continuously she had been obsessed with a fear first of disease and later of fecal contamination

After returning from a vacation and finding that her gardener had used manure to fertilize her impeccably kept lawn she first fired him and then joined the maid in scrubbing every inch of the floor of her home with a disinfectant Her husband the children and domestic help were forbidden to walk on the lawn or to step off the sidewalk The husband who was both tolerant and understanding of his wife's illness finally sold the house and moved in the hope of relieving some of her concern and the family's inconvenience

The episode which led to her being seen was a heavy rain which caused a storm sewer to overflow in front of the new home After this incident the patient became quite tense spent hours scrubbing and checking the bathrooms and at night had to check all the locks the fires and her family repeatedly before retiring

The husband the children and the maid had to remove their shoes before entering the house Consequently it was no longer possible for her to have guests in her home and she was in constant fear that someone would drop in and she would have to require their removing their shoes before she could permit them to enter As a result she feared the severity of her illness would become evident to her friends

This patient's entire waking time was spent in either carrying out her compulsive rituals or avoiding anxiety provoking activities which

would require even more compulsive acts. Her home and her life were so completely organized that superficially she gave the appearance of an efficient, poised and untroubled individual.

## DEPRESSIVE REACTION

In this reaction the anxiety is allayed and partially relieved by depression and self depreciation. This relief from anxiety is gained at the expense of the patient's developing hostile feelings toward himself in the form of guilt and self-condemnation. These reactions occur following an actual loss of either a relative or a friend or of personal security. Normal grief is accompanied by some inactivity (psychomotor slowing), restriction or loss of interest in the external environment, and a reluctance to accept outside activity or a replacement for the lost individual. In a depressive reaction the abnormality results from an excessive or prolonged reaction to the disturbing event.

As an individual endows another with feeling or affect, he also incorporates the individual in his own ego in approximately the same degree, if the incorporated individual is lost by death or rejection the patient's ego and his emotional balance are disturbed. A part of the ego is thereby lost which affects the patient's ability to function, as well as his behavior and his self-esteem. Since affect is composed of both love and hate, the guilt that may exist over the previous hostility toward the loved and lost individual is directed back at the patient as self-condemnation. The patient's hostility then is turned inward on himself.

The patient has a loss of drive, of interest, of appetite, and of satisfaction from his efforts. There may be a morning-evening variation in mood in which the patient is most depressed on arising and improves somewhat as the day continues. There may also be an entire day in which the individual feels more like himself, only to be followed by a day of increased depression. Those most subject to psychoneurotic depressive reactions are patients with a need for constant approval for the maintenance of their self-esteem, and consequently those most vulnerable to any rejections or failures.



The disturbance in the patient's psychogenic balance may be reflected by a withdrawal of interest in the external environment with a subjective and frequently hypochondriacal preoccupation with self. A gradual restitution to his premorbid state with a resumption of the individual's previous behavior may be expected.

Another type of individual showing such depressive reactions later in life is the restricted or rigid patient who has formed few gratifying relationships with other people, and is dependent either on his work or his spouse for his satisfactions and the completeness of his ego. The loss of external support by forced retirement or the death of the spouse may be devastating to the ego of such an older patient, he is inclined to the development of marked hypochondriacal states which may mask the underlying depression.

### CONVERSION REACTION

In a conversion reaction the patient literally converts his anxiety into a somatic symptom. If all of the anxiety is converted into a symptom the patient will show no evidence of tension or self concern and may be strikingly indifferent to the disability (*la belle indifference*). This capacity to convert anxiety into a symptom is pathognomonic of hysteria, it is unconsciously done and is beyond the awareness or control of the patient. For this reason it is without benefit to discuss or argue the anatomical impossibility of the somatic symptom with the patient.

The conversion symptom, besides relieving the anxiety, allows the patient to escape from a disturbing or unpleasant situation. There is then a secondary gain provided by the symptom such as an avoidance of intercourse due to dyspareunia in a sexually frigid female, or compensation in an occupational injury.

The relationship between the symptom and the secondary gain from the illness may be quite evident to the examiner; but the patient, being unaware of the evident relationship, may vehemently deny the secondary gain as a reason for the existence or persistence of the disability. If the gain from the illness is an obvious bid for attention or if the secondary gain is financially rewarding, the patient may erroneously be suspected of consciously malingering or feigning a symptom.

### *Characteristics of a Conversion Symptom*

1 The only demonstrable change in the involved area is a loss of function (paralysis, profound analgesia, or aphonia without substantiating physical findings)

2 The disability is not anatomical but follows the patient's physical concept of himself and the prevalent common idea of the organs of the body, and the type of disability accompanying their dysfunction. Freud observed the following: "The idea is not based on a profound idea of neuroanatomy but on tactile and, above all, visual perceptions." "The lesion in hysterical paralysis must be entirely independent of the anatomy of the nervous system, since hysteria behaves in its paralyzes and other manifestations as if anatomy were nonexistent, or as if it had no knowledge of it." "Hysteria is ignorant of the distribution of the nerves." "It regards the organs according to the common popular meaning of their names: the leg is the leg up to its insertion into the hip, the arm is the upper extremity as mapped out by our clothing."

3 There will usually be an obvious secondary gain from the illness which allows the patient to escape from an unpleasant situation.

4 The more completely the anxiety is converted to a somatic symptom, the less tense or anxious and the more indifferent the patient will appear.

5 The symptoms are likely to be aggravated by attention or treatment of the involved area.

### DISSOCIATIVE REACTION

These reactions are much less frequent but much more dramatic than conversion symptoms. In these the hysterical patient unconsciously dissociates from his awareness unacceptable behavior or circumstances that are intolerable to his ego and from which no other escape is possible. Literally, what cannot be accepted or endured is unconsciously denied; not only is the specific activity or circumstance avoided, but so too are the incidents associated with the disavowed behavior and the situation in which it occurred.

If this dissociative reaction or "splitting of consciousness" is complete, the patient may have a total "amnesia" for a particular pe-

riod The duration of the amnesia varies and may be followed by an awareness of his surroundings but with an inability to remember his name or who he is. Such patients may be quite clear in all spheres except for a circumscribed period of time involved in the memory loss, but in spite of this rather gross psychic defect of which they are aware, these patients may show little or no evidence of concern, agitation or anxiety over the loss.

# 6

## *HYSTERIA*

Background  
Personality of the Hysteric  
Marital History  
Interpersonal Relations  
Symptoms of Hysteria  
Diagnosis

## *Hysteria*

*People really do exist who believe they are what they pretend to be —JUNG*

In addition to obvious conversion and dissociative reactions there are patients who show persisting patterns of behavior which in the past have been described as hysterical. This term is no longer included in the standard classification. However these patients still exist and the following section is an attempt to make the female hysteric recognizable.

Although both sexes are affected the female is more likely to seek treatment but is less easily recognized. There is at times a tendency to attribute unexplained somatic symptomatology to hysteria. This is a hazardous decision unless the patient's history as well as her complaints substantiate the impression.

### BACKGROUND

The hysterical patient has had an interesting career in recent medical history. During the latter part of the 19th century there was question as to whether such patients presented a medical problem since it was presumed they deliberately deceived the doctor. Freud lists as one of Charcot's major contributions his dignifying hysteria with his interest and his insistence that this was a problem requiring management by the physician.

A goodly part of psychiatric practice during the 19th and the early part of the present century was composed of hysterical individuals as the writings of Janet, Breuer, Freud and others amply show. Kolb points out that today patients with gross hysterical

symptoms do not consult psychiatrists and are not referred to them, one reason for this being the fact that psychiatrists do not wish to see such patients. He further finds that hysteria is more frequent than rare in the patients seen in medical centers and large clinics. Chodhoff and Laughlin, on the other hand, consider hysteria to be decreasing in incidence due to increased education, decreased sexual prudery, and a rise in the level of scientific knowledge.

In 1905 Freud revised his earlier theories regarding sexual trauma, accidental influences, and a passive attitude during early sexual experiences as being etiological in the production of hysterical illness later in life. This revision followed his finding that the sexual history of the normal did not necessarily differ from that of the neurotic and he concluded "it was no longer a question of what sexual experience a particular individual had had in his childhood, but rather of his reaction to these experiences . . ." Dynamically, then, this would require that the unconscious of the hysteric and her reactions be swayed by logic or at least by learning rather early in life, if an improved state of the education of the population as a whole is accepted as the cause for fewer hysterics being seen by psychiatrists.

From whatever reason, hysteria is less frequently seen in the private practice of psychiatry than it was even 30 years ago, and the term disappeared, along with the patients, in 1952. Another explanation is possible for these patients being seen less frequently, namely, that the symptoms of hysteria have altered in keeping with the culture; the patient seeks treatment for the diagnosis she makes on herself and merely chooses the physician whom she thinks should treat her complaint. This choice seldom involves the psychiatrist. Sydenham's earlier description probably still applies to our modern, more learned hysteric. He stated: "Nor is this disease only frequent, but strongly various that it resembles almost all the diseases poor mortals are inclined to; for in whatever part it seats itself it presently produces such symptoms as belong to it."

Since hysteria is defined as an unconscious process which produces dramatic physical symptoms classically involving voluntary muscle groups and organs of special sense, the patient could hardly be consciously aware of the emotional origin of the illness and would

logically seek relief from the physical complaint. The success such patients occasionally experience in their search for relief and demand for treatment may be recorded on their abdomens in the form of incisional scars.

The literature on hysteria reveals that this disorder is described with approximately equal frequency by psychiatrists and other physicians. The most obvious difference in the reports is the tendency of psychiatrists to be concerned with the cause and for the nonpsychiatrist to stress the results of treatment.

The advantage to the neuralgic female of being considered hysterical and consequently suffering only a slight was pointed out by Sir Clifford Allbutt since this same female's symptoms could be attributed as easily to her uterus which like her nose might be a little to one side or inclined to run and subsequently she might be fixed by the arrow of hypochondria.

### PERSONALITY OF THE HYSTERIC

The female hysteric shows certain characteristics both in personality and complaint. Such patients usually have a history dating from childhood of excessive demands for attention. The greater this life long demand the more marked the hysterical features. These needs are more likely to be catered to or encouraged by the patient's parents than her contemporaries and as a result she may early expect undue consideration from casual friends and consequently be routinely disappointed.

She is soon convinced of the falseness of those of her own sex. She learns early in life that you cannot trust other people and is able to recount numerous examples that confirm her suspicions. By adolescence this experience of insincerity in friends becomes common place. The patient forms a superficial relationship which fails because of her unrealistic demands and this loss is histrionically magnified and becomes a pattern followed by the patient in her relationships with her peer group. This type of activity offers little gratification.

Such a pattern of behavior protects the patient from rejection by preventing her from becoming affectively involved. Ferenczi described a similar circumstance in an hysterical girl who in spite



of an apparent reserved and confident demeanor, was extremely self-conscious and consistently refused to enter into any competition with other girls "to protect herself from the risk of too painful disillusionments."

He adds that this patient "showed herself seriously wounded at the purely medical handling of her repeated love declarations," and a few hours were lost by the production of resistance to this hurt to her conceit, during which many earlier similar "insults" were recounted.

The hysterical female may or may not mature earlier than most but ordinarily she utilizes her maturity to the fullest as an attention-getting mechanism. The emphasis on her developing physical sexuality prompts interest in males and hostility in females, and she is usually "talked about." Being discussed provides attention of a sort and her seductive behavior before the group may be in striking contrast to her attitude when alone with an individual.

She makes it a point to regard her contemporaries, in whose presence she is uncomfortable, and their interests as infantile and herself as more adult. She prefers older mature males and not infrequently between her sixteenth and eighteenth year she leaves school and marries an exciting but not too responsible male.

### MARITAL HISTORY

The first husband usually turns out to be, by her definition, a "sex maniac," that is, he expects her to have intercourse. In addition, he is not sufficiently attentive or he fails to regard her spending the day in the home as an event routinely requiring praise. The relationship soon palls, she returns to her parents, and shortly after the marriage terminates. Such women are more frequently frigid than infertile, and there is usually a child as a result of this first marriage.

After a few years, the patient marries again. This choice is more deliberate; the male is older and more understanding, that is, he rarely demands intercourse and when he does he appreciates the sacrifice the wife is making solely for his pleasure. The failure to gain satisfaction sexually or from the ordinary routines of living and

the isolation which she feels in the presence of other females require that other sources of gratification be found.

*If the hysteric is unfortunate enough to again marry an individual who has no need of a demanding wife, her incessant bids for attention will soon become intolerable and another divorce will ensue. Such patients have no choice but to repeat the procedure until the "right man is found."*

A very attractive 25-year-old nurse was seen in consultation because she has had episodes of diplopia, unsteady gait, and increasing muscular weakness. The diagnosis of multiple sclerosis had been considered.

When interviewed, she described the above symptoms but when her muscular weakness and fatigue were mentioned, she became noticeably less vigorous, and said she had trouble staying awake. Her history revealed that the previous year during a poliomyelitis epidemic, she had suddenly developed a weakness of her lower extremities and was hospitalized with a diagnosis of poliomyelitis. She was discharged a week later without any residual disability.

She had been married secretly during the last year of training but was divorced soon after she graduated. This husband was described as "no good," he was mean to her and "thought of nothing but sex." The present husband was 16 years her senior and "worried about her all the time."

Her husband actively encouraged her symptoms and her dependence by insisting she should rest and call him immediately if she had any trouble. The patient's neurological and physical findings were not unusual. In addition to her other previous diagnoses, she had also had brucellosis although no positive cultures were ever obtained. She had been under medical care most of her adult life.

The areas from which satisfaction can be gained are extremely limited since hysterics demand the attention of others while offering little in return. This can be accomplished by the judicious use of their sexual attractiveness, or by becoming ill. The attractive female hysteric has little difficulty in attracting the male, who normally finds it impossible to comprehend that such patients want no more than attention; they suspect it but they prefer not to believe it.

The husband of the hysterical female must accept in good grace his wife's undue attention from other males, her unceasing conflicts with their suspicious wives, or a sudden illness which disrupts previously made plans if she is not catered to sufficiently. He either accepts these restrictions in good grace or bows out of the marriage.

Typically, the husband of the hysterical patient is overly attentive by prevailing standards, he never grows bored by her excessive demands and is always ready to dash home from the office with the appearance of each new crisis. If he happens to be a physician, he will probably have no more insight into his wife's problem than the laity.

Characteristically, the hysteric's husband cannot be gotten out of her room at the hospital, he is there early and late, apologizing to the nursing staff for his wife's demands. The nursing personnel are not always too sympathetic to the hysteric's needs and her complaints. When seen in consultation, the patient's concerns are frequently divided between her somatic disabilities and such problems as an inadequate vase for her flowers, the hospital's failure to provide a telephone, and her displeasure with the room. There may be an evident pride in the fact that she presents a problem in diagnosis.

### INTERPERSONAL RELATIONS

The female hysteric apparently is ill at ease and in conflict with other women throughout her life. Men early become predictable since their interest is either obviously or covertly sexual. Not infrequently the patient describes a sexual approach during her adolescence by an older male, most often a relative and not rarely the father. If the father is the offender, the hostility will usually persist consciously since she never trusts him again. This hostility, in time, may also be directed to other males of any age who approach her sexually. The patient's attitude may coincide with that of the mother, and her opinion about males may very closely resemble that expressed by the mother about the patient's father.

Clinically, these types vary from the extreme of the rather amorous, overweight individual, who continually exists on the verge of a state of collapse from some cause or other and requires the

24 hour supervision of a relative, nurse or physician. The opposite extreme is seen in the attractive wife who finds housework far from satisfying, who is uncomfortable with the other women in the neighborhood, and soon returns to the occupation in which she was successful before her marriage. Except for a persisting frigidity, an occasional somatic complaint, and a distrust of other women she is asymptomatic.

### SYMPTOMS OF HYSTERIA

Characteristically, the only finding in an hysterical symptom is a loss of function. It has been repeatedly noted that "the symptomatology of hysteria is full of anatomical impossibilities, and that the popular idea of the organs or parts of the body determine the areas of involvement. However, it may occur that after repeated examinations the symptoms become more anatomical as the patient learns from the examiner and is influenced by his concern.

In addition, the loss of function should relieve the anxiety and provide the patient with a secondary gain from the illness or the disability it imposes. Breuer pointed out the hysteric's need for being ill in contrast to the hypochondriac's fear of illness, this need in hysteria was said to arise from the patient's desire to convince herself or others of the reality of the sickness. He added that unconscious ideas or complexes might reduce the hysteric's awareness as preoccupation does in the normal individual.

This desire to convince self and others of the reality of the illness is sufficient to make these patients not only accept but seek surgery which, among the laity, is rather conclusive proof of the existence of an illness.

The frequent inability of the hysterical female to respond sexually may arise, as Ferenczi said from the fact that they may regard coitus as an activity which, either directly or subsequently, is calculated to injure life or limb, and in particular damage the sexual organ."

Perhaps of greater importance than the fear of the destruction of an organ, is the threat to the concept the individual holds of her self if she responds sexually. This concept of self is seemingly poorly drawn in the hysteric and may have prompted Jung's remark that

"people really do exist who believe they are what they pretend to be," a rather malignant state in itself.

Hysterics easily adopt various roles, or literally "try on" different personalities, none of which satisfy, either due to a degree of insecurity that requires constant reassurance or an inability to obtain gratification from the ordinary demands of living. Finally, the point mentioned earlier by Ferenczi, a fear of competition with other females and the possibility of disillusionment may be so threatening to the individual's ego as to make the hazard of rejection or failure too great to risk. The hysteric is probably as isolated and as fearful of her peer group as the schizophrenic, and not only fails to gain reassurance from her contemporaries but feels herself constantly threatened by them.

The capacity to isolate that which is intolerable to the ego by dissociation or to convert anxiety to a symptom perhaps depends on the amorphous and changing concept of self, and the fact that, as Kraepelin noted, "ideas take on the force of sensations."

In some instances, the patient seems trapped by the symptom. The stress which provoked it may have passed but, having been previously refractory to treatment, there is no graceful way out. As Meyer said: "We have to recognize that we are dealing with what we might call a complaint become a disease, not complaint of disease, but complaint as a disease . . ."

The hysteric presumes the physician is first a male and second a doctor, which is difficult to refute, and she can hardly be expected to evolve a whole new method of behavior for this particular circumstance. When a previously successful method of gaining attention fails, it may be productive of anxiety, which has to be controlled by more symptoms, hostility, or more overtly seductive behavior. Possibly the greatest therapeutic hazard is the surrender to the patient's demand for treatment of her diagnosis, even though no basis for the symptoms can be found.

### DIAGNOSIS

The diagnosis of hysteria does not rest on an unexplained symptomatology, as evidenced by the number of those with multiple sclerosis or other degenerative disease who are considered hysterical

# 7

## *PSYCHOPHYSIOLOGICAL, AUTONOMIC, AND VISCERAL REACTIONS*

Mechanism of and Differences between Psychophysiological and Conversion Reactions

Treatment of Psychophysiological Reaction

Types

Psychophysiological Skin Reaction

Psychophysiological Musculoskeletal Reaction

Psychophysiological Respiratory Reaction

Psychophysiological Cardiovascular Reaction

Psychophysiological Hemic and Lymphatic Reaction

Psychophysiological Gastrointestinal Reaction

Psychophysiological Genitourinary Reaction

Psychophysiological Endocrine Reaction

Psychophysiological Nervous System Reaction

Psychophysiological Reaction of Organs of Special  
Sense

*Psychophysiological, Autonomic,  
and Visceral Reactions*

Periodically, the patient as well as his illness is rediscovered. Certain similarities among those afflicted are also noticed, they may be similar in body habitus, in response, in type of gastric mucosa or even in personality. The concept that each psychophysiological disorder has a particular 'personality constellation' has a following of psychiatrists who are inclined to agree, and those who do not agree.

For instance, Alexander feels that "vegetative dysfunction results from specific emotional constellations," and adds that current investigations are all in favor of the theory of specificity. This specificity is clarified only by careful and minute observations, and the best technique to achieve this clarification is prolonged psychoanalytic interviews.

Saul describes the picture regularly found in the aggressive business man with a gastric ulcer as a 'repressed longing for a retreat to love, care, and protection.' He states that in the gentle considerate individual with hypertension 'chronic rage hidden beneath the surface' is a regular finding, underlying the symptoms of asthma are a "sudden threat to the attachment to the mother and a repression of the consequent tendency to cry out."

Cobb, on the other hand, says that, although the sketching of psychological word profiles 'is an intriguing pastime,' "it is too impressionistic to rate as a science." He further questions whether the "personality profiles" used in psychosomatic research are worth



anything at all. The methods used in describing and codifying personality are compared to those used in anthropological measurement and are said to be so inferior "that correlation between physical types and specific disease would probably be worthless."

It needs to be stressed that an awareness of the psychophysiological components of an illness is the beginning but in no wise the end of therapy. In the "prepsychosomatic" days to conclude the patient had a "gastric neurosis" was not in itself therapeutic; and it is hardly more curative to decide he has a "psychophysiological gastrointestinal reaction." The problems of treatment have not been altered with the terminology. Not too rarely, the physician tends to give dynamic explanations to patients with these reactions; if the patient is to be helped he must describe, understand, and accept these factors and not merely hear an explanation of them.

These reactions were previously described as "psychoneurotic reactions," "somatization reactions," "organ neuroses," or "anxiety states."

#### MECHANISM OF AND DIFFERENCES BETWEEN PSYCHOPHYSIOLOGICAL AND CONVERSION REACTIONS

Psychophysiological reactions represent the visceral expression of affect; the symptoms result from a normal physiological response to emotions which are chronic and exaggerated. The subjective experience—"the feeling" or awareness of the emotion—is repressed. This excessive stimulation, long continued, may lead to structural changes.

The psychophysiological reactions differ from conversion reactions in the following ways. (1) The involved organs and viscera have an autonomic innervation (rather than those organs and parts under voluntary control, as occurs in conversion reactions). (2) These reactions fail to relieve the anxiety. (3) The symptoms are of physiological rather than symbolic origin. (4) They frequently result in structural changes which may threaten the patient's life.

#### TREATMENT OF PSYCHOPHYSIOLOGICAL REACTIONS

In the treatment of these reactions it is no less reprehensible to ignore the structural changes which may occur with the illness than

to deny the emotional aspects which aggravate them. When these structural changes result in disfigurement, as may occur in skin reactions, and in the emaciation seen in the later stages of colitis, another factor is added. The patient has these changes to accept in addition to the problems which preceded and precipitated them.

There is agreement that the physician treating these psychophysiological reactions needs to be aware of the patient's difficulties within himself and with other people, as well as the dysfunction of the involved organ. The patient should be encouraged to express the emotion which his conflicts produce in the hope that this expression will decrease the excessive autonomic stimulation. The rapidity with which he can express this emotion is governed not only by the patient's ego but by the structural changes in the involved organ as well.

*Any interpretation which may be traumatic, or 'deep probing' should be left to therapists of long experience because of the effects of even a temporary increase in tension on the organ involved.* Psychotherapy in this group of patients varies from the treatment given those with psychoneurotic reactions only in the added complication of the physical changes. It has been pointed out that the psychopathology in these reactions is not unique and does not require a separate description.

Some less obvious areas in which unexpressed emotion apparently influences the functioning of the autonomic nervous system adversely include infertility, allergic phenomena, and thyroid dysfunction. The frequent occurrence of pregnancy in a previously infertile female after a child is adopted (or even if children are kept in the home) must result from a change in the emotional state of the mother. Frigidity without demonstrable pathologic conditions requires some explanation.

There is no doubt that the allergic individual is sensitive to particular substances, but the patient who, at the mere mention of ragweed, begins to weep and rub his eyes and the asthmatic whose wheezing ceases after he receives saline which he believes to be adrenalin, would make one pause to consider the effects of suggestion and conditioning in medicinal treatment of allergies.

The relationship between emotional trauma and hyperthyroidism is not yet clarified, but the differentiation between anxiety and

hyperthyroidism is more exact than in the past since fewer anxious patients are seen who have had a thyroidectomy. The differentiation of mild or questionable hyperthyroidism requires as much familiarity with the findings on anxiety as with the latest laboratory procedures.

## TYPES

### *Psychophysiological Skin Reaction*

This category includes such skin reactions as neurodermatoses, pruritus, atopic dermatitis, hyperhidrosis, and so forth, in which emotional factors play a causative role.

### *Psychophysiological Musculoskeletal Reaction*

Included here are musculoskeletal disorders such as "psychogenic rheumatism," backache, muscle cramps, myalgias (to include some cases of cephalgia, tension headaches) in which emotional factors play a causative role. In this group, differentiation from conversion reactions is of prime importance and at times is extremely difficult.

### *Psychophysiologic Respiratory Reaction*

Here may be included cases of bronchial spasm, some hyperventilation syndromes, sighing respirations, and hiccoughs, in which emotional factors play a causative role.

### *Psychophysiologic Cardiovascular Reaction*

This category includes such types of cardiovascular disorders as paroxysmal tachycardia, hypertension, vascular spasms, and migraine, in which emotional factors play a causative role.

### *Psychophysiological Hemic and Lymphatic Reaction*

Here may be included any disturbances in the hemic and lymphatic system in which emotional factors are found to play a causative role.

### *Psychophysiological Gastrointestinal Reaction*

Included here are such specified types of gastrointestinal disorders as peptic ulcer-like reaction, chronic gastritis, ulcerative or

mucous colitis, constipation, hyperacidity, pylorospasm, "heart-burn," "irritable colon," and "anorexia nervosa," in which emotional factors play a causative role.

### *Psychophysiological Genitourinary Reaction*

This category includes some types of menstrual disturbances, such as dysuria, in which emotional factors play a causative role

### *Psychophysiological Endocrine Reaction*

Endocrine disorders in which emotional factors play a causative role are included in this category.

### *Psychophysiological Nervous System Reaction*

Included here are psychophysiological asthenic reaction, in which general fatigue is the predominating complaint. There may be associated visceral complaints. The term includes many cases formerly called "neurasthenia." In some instances an asthenic reaction may represent a conversion reaction; if so, it will be so classified, with asthenia as a manifestation. In other instances it may be a manifestation of anxiety reaction and should be recorded as such.

Also included in this category are convulsive disorders not otherwise classifiable in which emotional factors play a causative role. Differentiation must be made from the convulsions of conversion reaction.

### *Psychophysiological Reaction of Organs of Special Sense*

Here may be included any disturbances in the organs of special sense in which emotional factors are found to play a causative role and in which conversion actions are excluded.

## 8

# PSYCHOTHERAPY

The Interview

Evaluation of the Patient

Patient's Concept of Himself

Plan of Treatment

Factors Determining Plan of Treatment

Duration of Illness

Acute

Chronic

Periodic Episodes Followed by Remission

Personality Disorders

Etiological Factors in Emotional Difficulties of  
Recent Onset

Unexpressed Hostility

Relatives

New Supervisor

Marital Difficulties

Identification with Another

Dreams

Factors which may Interfere with Treatment

Relationship with Patient

Premature Diagnosis

The Therapist's Conflicts

Advice and Reassurance

Terminating Treatment

## *Psychotherapy*

Psychotherapy like any other medical procedure has indications and limitations—a beginning and an end

It is not a routine method to be similarly applied to all the purpose the goal and the technique are determined by the individual patient

Psychotherapy may be defined as a form of mental treatment which is primarily verbal. *Ewalt confines the term to the physician's intentional acts by which he hopes to guide the patient's thoughts and emotions to relieve his symptoms and where possible the more primary disturbance*

When psychotherapy is not restricted by this element of intention or purpose Sullivan's appraisal of this method should be recalled

If one is governed by no principles but some vague beliefs—as in something like free association—I think brief psychotherapy is very likely to be measured in terms of decades

Freud emphatically rejected the view that treating the patient meant we should carve his destiny for him force our own ideals upon him and with the arrogance of a creator form him in our image and see that it was good. It is sufficient that the physician's efforts be purposely directed to making the patient more tolerant of himself more spontaneous and more aware

The methods suggested in this chapter are intended as directions for the physician to follow

## THE INTERVIEW

The majority of patients for whom psychotherapy is indicated are anxious, and since the problem is to determine what is causing their anxiety, the patient must not only be allowed to talk but he must be made comfortable enough to talk. The therapist is a stranger; the patient hopes he will be an understanding stranger endowed with empathy and therefore somewhat aware of the patient's discomfort.

The therapist should not attempt to give himself an air of omnipotence, inferring by a smile or an interpretation that he knows, without hearing the history, the hidden meaning of a patient's symptoms. This implies that the therapist already possesses the answers and knows what the patient is reluctant to describe, and infers that the patient will have to be more careful if he does not want to reveal himself. It is enough for the therapist to be aware, interested, and objective.

Direct questions at the beginning of treatment regarding past sexual activities or hostile attitudes toward parents are more apt to bring forth socially acceptable answers than facts, and this only adds one more block to their being verbalized later by the patient. The goal of therapy is a more adequate and comfortable adjustment of the patient to himself and others; and disturbing incidents (that is, traumatic events) should only be sought or probed for as the patient is able to tolerate them consciously.

Where the therapist places himself in the room during the interview will probably depend on his own comfort. Many agree with Freud that the prospect of being "gazed at for eight hours a day (or more)" is less than desirable; or having patient observe the interviewer's reactions to the history may be detrimental.

The patient's chair may be faced slightly away from the physician to avoid a "question and answer" session or a tendency to discussion. There is little need to take verbatim notes of the interview since this may cause the patient concern, as well as distract the physician and prevent him from training his memory. A short summary following the interview serves to weigh what has transpired and provides an account of the patient's progress.



The decision as to how much direction should be given to the interview is based on how *productive* the patient is and whether *there is evidence of a need to talk*. If there is an obvious push of speech or pressure to justify an attitude or past behavior this should be allowed since the motivation may become evident as the interview progresses. Others talk at great length to make something clear but qualify their statements so adequately that the whole means nothing (Sullivan)

A patient at the first interview immediately began describing in minute detail her inconsiderate husband and her dominating relatives. Near the end of the hour she paused and asked: "Now do you have any more questions?"

Not today was the reply.

The diatribe continued during the second interview with an occasional bid for an argument. It was not until the third hour that the patient became sufficiently at ease to allow any questions from the interviewer.

Yet during her discourse many of her anxieties as well as her aggressions had become obvious. She repeatedly stressed the influential people her husband knew, the irritating security of her mother in law — not one damn thing ever bothers her — the private clubs they belonged to — nobody looked down their nose at her anymore — and how much entertaining she was expected to do for business reasons.

As Jung has mentioned, extremes should always make one suspicious of the opposite, and in subsequent interviews the patient described her early history of insecurity and fear of ridicule which she had always met by aggressively taking the offensive, *attempting to conceal her inadequacy*.

The original interview may be difficult to terminate since if it has been properly conducted the patient realizes she has done all the talking and suddenly feels it is time to be told something. It should be noted that this demand for information may be prompted as much by a need to explain to a husband what transpired as an actual desire on the patient's part for information. The more experienced (that is, the more secure) the therapist, the less he will need to explain the interview when it is terminated. The psychiatrist is an expert and he should be expert enough to be done

when he is through" (Sullivan). The patient may be told without hesitation that the physician does not yet have enough information to form an opinion or give advice.

If the patient has been on tranquilizers or sedatives, a decision regarding their continuation should be reached before the end of the interview, and any questions the physician needs answered to form an opinion should have been clarified. Otherwise, the patient will soon utilize the end of the interview as a question and answer period.

### EVALUATION OF THE PATIENT

In no other treatment is it more essential to form an impartial opinion of the patient based on his capacities and limitations as they are revealed. Freud advised that in treatment the therapist take the surgeon as a model and put aside "... all his own feelings, including that of human sympathy" and concentrate on his task. This applies equally in evaluating a patient.

Unless the patient is seen as he is and not as the therapist would have him be, an understanding of the basis of his conflicts is not possible. If the therapist's ambitions are beyond the patient's abilities, both will be frustrated and treatment will progress slowly if at all.

Too frequently a symptom or its symbolic implications may be diligently pursued without sufficient attention to the patient who has it. In other instances the individual's occupation, accomplishments, or appearance may distort the examiner's view. The therapist can validly compare the patient's responses to his own only if he is treating an individual similar in sex, age, background, and experience. The symptoms should become meaningful as the history and response to past experience are expressed.

As the history is obtained an impression of the patient, based on his abilities, his tendency to repeat the same behavior, or to become involved in similar types of conflicts, should be clarified. To have validity this impression must be consciously arrived at and must consider the patient's age, endowment, and his success or failure in his chosen occupation and social group. The patient's goals and how realistic they are in the light of his abilities should be noted.

The physician should consciously resist precocious conclusions, and he must be able to alter his original impression in accord with what later becomes evident in treatment.

Patients not infrequently set impossible goals for themselves to maintain their own ego. When the goal is impossible to attain their failure may be comfortably attributed to forces outside themselves rather than faults within. Similarly, to make less painful the hazard of rejection a patient may choose another to whom he feels superior (as an object); then if rejection occurs his loss may be rationalized as beneficial.

A slip of the tongue or a character trait of the patient may confirm or alter the impression the physician evolves; but unless they are related to the patient's previous experience they remain only isolated and often misleading fragments.

An extremely anxious 35-year-old male, when first seen, was unable to sit during the interview; he would retreat to the farthest corner of the room and describe his activities rapidly, pausing to justify each bit of behavior after he described it. He was unable to remain in the waiting room if other patients were present but would stand alone in the hall or disappear into the men's room if noticed.

He prided himself on his regular attendance at church but would alternate this with a description of how easily the other members were deceived by the "false front" he put up. He consistently attempted to describe his behavior as erratic but never failed to use the term "erotic." He was of superior intelligence, and bordered on a psychotic state; to have dwelt on his unconscious use of the word "erotic" to characterize his behavior would have been more than his poorly integrated ego could have accepted.

### PATIENT'S CONCEPT OF HIMSELF

This is difficult to arrive at since the patient may wear one mask in public and another when he is alone, and still another on Sunday morning. However, an awareness of the patient's concept of himself is essential in understanding his behavior and conflicts.

This concept is probably only conscious when the patient experiences guilt over some activity unacceptable to his ideal. Vague though this concept is, it functions continuously to insure the coherent integration of the ego by automatically rejecting behavior

which might be immediately or eventually threatening to the individual.

The concept the patient holds of himself can hardly be determined by direct questioning, since it is not conscious except possibly in megalomania. The concept is most evident in situations in which the patient experiences guilt and anxiety.

The guilt, anxiety, and unexpressed hostility the patient's history may reveal also reveal the concept he holds of himself and the restrictions this concept imposes. More obvious evidence of this inner ideal are his bearing, his dress, his manner, and his relationship with others.

### PLAN OF TREATMENT

Unless the therapist clarifies the source and duration of the difficulty and determines how he feels it may be altered, the subsequent interviews will lack continuity. Some goal, end, or purpose of treatment must be established on the basis of the therapist's evaluation; otherwise each interview may be dominated by some episode that occurred between visits, or a dream the patient brings in which fits nowhere in particular; or the patient may share in the lack of direction and be late to the interview or fail to produce any new material. The therapist must direct the treatment; "... the expert does not permit people to tell him things so beside the point that only God could guess how they happened to get into the account" (Sullivan).

#### *Factors Determining the Plan of Treatment*

##### URATION OF ILLNESS

*Acute.* Those patients whose symptoms are of recent onset more frequently have an external cause for their troubles. In the patient who can date the time his troubles began and who was apparently well adjusted, a precipitating cause in the form of interpersonal conflict or a threat to his security should be sought. These patients have the best prognosis and brief psychotherapy is indicated with weekly interviews for from three to six months.

*Chronic.* As opposed to those patients with illnesses of more recent or acute origin, there are those in whom the symptoms have no clear-cut onset; the patient does not recall when he was without

problems nor precisely when he was last well. Such patients have usually had treatment from several sources, including previous psychiatric interviews.

Their difficulties seem to be primarily of internal origin, they may be repeatedly involved in one difficulty after another, each interpersonal contact that progresses beyond the casual may terminate in discord. Hearing such a patient's history, it is at first difficult to see how so much trouble could have come their way, but as the history is given it is increasingly more obvious that the problems did not "just happen" but that the turmoil has been actively sought. These patients, depending on their discomfort and their interest in treatment, require either prolonged psychotherapy or superficial reassurance when they will accept it.

An attractive 23 year-old girl was seen after she attempted to throw herself in front of a car. Her I Q was 124 and she had had previous psychiatric treatment. The history was unusually traumatic. She was seduced by her stepfather at 14 and contracted gonorrhea. The mother blamed her instead of the stepfather for the seduction.

The mother showed little interest in her when she was a child, and her clothes made her a source of ridicule for the other children. This became so intolerable that she would occasionally hide during the day to avoid the teasing at school.

At 17 she superficially cut her wrists in an impulsive suicidal attempt; subsequently whenever she became angry she would cut her arms or legs with a razor. She denied any sexual stimulation from this cutting but said it did relieve her anger and her anxiety. When first seen her arms and lower legs bore innumerable incisional scars. She was well known in the emergency rooms of neighborhood hospitals.

She was frequently beaten by her boy friend, who on one occasion shoved her from a moving car and she suffered a severe back injury. She found a girl friend who promptly approached her homosexually. She took money home for the younger children in the family and the mother used it to buy whiskey.

She was extremely self-conscious and was unable to eat with other people, having to buy her food and eat alone in her room. She could wear only slacks and long sleeved dresses otherwise people would ask about the scars. She obtained a job and the second day her employer approached her sexually.

She was seen in a seminar and while the interviewer was out of the

room she became angry at a question by the instructor, ran her hand through a window, and severed three tendons.

She was somewhat a problem.

Obviously, chance alone could account for only a few of her troubles; and it was equally obvious that she sought situations which duplicated those she had undergone earlier in her life when they ceased to occur spontaneously. She was seen over an 18-month period, responded well, and when last heard from three years later she had continued to maintain this improvement.

*Periodic episodes followed by remission:* Some patients have had one or more similar episodes previously, in which the symptoms may have varied, but the incapacity and duration of the illness were about the same as that shown during the present trouble. Depending on the predominance of the presenting complaint, these patients may have been treated for various physical disorders. Characteristically the findings on which treatment was based were vague and atypical, and the response to somatic therapy was neither as prompt nor specific as one would expect.

These illnesses may be presumed to arise from the same unknown etiology as the more obvious and more severe affective reactions. If the patient has regained his premorbid level of adjustment after the previous episodes, his prognosis would seem to be good. Similar factors which may have preceded each episode should be sought. These patients may have little interest in continuing treatment after an episode ends.

*Personality disorders.* This is a group of patients, more often brought to treatment than seeking it, from whom society and the family have come to expect too much. They accept treatment not so much for internal reasons but to pacify those in their environment. They present problems of great variety which in essence are but manifestations of a prevailing pattern of action or behavior which keeps them in conflict with others.

#### *Etiological Factors in Emotional Difficulties of Recent Onset*

The following are frequent sources of conflict and anxiety in patients who were previously comfortable. The patient may not describe the conflict when giving his history, or, if he does mention it, may not relate it to his discomfort.

## UNEXPRESSED HOSTILITY

For conscious reasons an individual may endure an imposition rather than risk overt conflict. "Man collides with his environment more from fears and hostility than because of his instincts" (Horney). Those who dislike disharmony and argument are, for these particular reasons, more vulnerable to any imposition. The following are commonly found sources of trouble:

*Relatives.* A relative, most often a mother-in-law, is interfering with the patient's home life or criticizing the patient to his spouse. The criticism varies from overt derisive remarks to a condescending and too tolerant attitude.

A husband who has always been tolerant of a too possessive mother may conclude that his wife's complaints about being criticized are exaggerated. Or he may agree that his mother is demanding but may expect the wife to accept her interfering, as he always has, because his mother "is getting old," "hasn't too much longer to be with us," or for some other equally unsatisfactory excuse. If the couple is in some manner financially dependent on the mother the husband's demand that she be tolerated may be even more insistent.

*New supervisor.* A new supervisor where the patient works may humiliate or embarrass him before others; or the patient is bypassed when he should have been promoted. By remaining on the job he loses stature and self-confidence, but his obligations are such that he cannot risk changing jobs. A troublesome neighbor may have the same effect on a patient.

A 34-year-old engineer was seen after repeated physical examinations and laboratory tests had failed to reveal a cause for his various physical complaints. He dated the onset of his trouble from an acute bout of anxiety which occurred in a crowded restaurant three months earlier. He referred to this as the "spell" he had had and added there was nothing wrong with his "head or his sex life."

When questioned about his work he showed considerable pride in the rapid progress he had made in the large corporation which employed him. When asked about future promotions he immediately began describing the incompetence of the vice-president who was his superior. He stated that previously he had been active, interested, and productive; but since his last promotion he just "sat on his tail" and tried to act busy.

Two others in his office had quit the company and another had asked for and received a transfer. The patient said he would quit in a minute except for his seniority, and that he was reluctant to ask for a transfer because his wife did not want to take their children out of school, sell their home and move to another city. He did not consciously relate this daily turmoil to his symptoms.

*Marital difficulties* Perhaps one of the most frequent causes of sexual incompatibility is the husband's "taking the wife for granted." To the female, intercourse can seldom become routine or habitual, to the husband it may. Too, a diaphragm is not a particularly romantic object to the wife and there may be resentment over making such an elaborate effort merely to fulfil an expected obligation.

Another cause of a lack of sexual response in the wife is resentment over a lack of consideration or attention by the husband. The wife who is ignored (particularly at a social gathering), or feels herself belittled or humiliated in a disagreement may be unable to respond sexually due to her resentment. The wiser husband probably wins few arguments before retiring.

Infidelity in the spouse is perhaps the most frequent cause of a persisting frigidity in a previously responsive female. In addition to the anger over the act itself there is the concern that her husband's activity may become common knowledge to her friends. A sexually inadequate husband or a too aggressive wife may create a chronic state of tension and dissatisfaction in a marriage.

Still other marriages seem to have been entered into on a temporary basis and to have become permanent through habit rather than compatibility, the only emotion shown may be anger. It is superfluous to add that with the patient who attributes all of his symptoms to an incompatible marriage, the suggestion that a divorce be obtained is neither sufficient, professional, nor logical unless the patient is a defective, this solution must surely have occurred long before. The motivation for continuing the marriage should be understandable from the history.

#### IDENTIFICATION WITH ANOTHER

A disabling or mortal illness in a friend or acquaintance of the same age, sex, and occupation as the patient may produce anxiety



The fear of a similar fate may be too threatening to remain in awareness, and if medical advice is sought the friend's death may not be mentioned. The most frequent concern in the male is the fear of a "heart attack" and in the female, of having a cancer.

## DREAMS

In brief psychotherapy dreams serve an important function in treatment. They reveal meaningful associations, situations, and persons that may not be recalled consciously and would not be revealed in the history.

Perhaps they are of even greater importance as an indicator of a patient's appraisal of himself as revealed by his activities in the dream situation. He may appear aggressive, secure, and composed in reality and show an opposite type of response in his dream. The content of the patient's dream may also indicate changes occurring during treatment as the individual becomes less anxious.

The "wish fulfilling" aspects of the dream content may be apparent to the interviewer but concealed from the patient. The patient's explanation of his dreams reveals what he can and cannot consciously tolerate. There is no gain in attempting to persuade him to accept the physician's interpretation.

Possibly the greatest use of dreams in brief psychotherapy is the added insight they offer the therapist in understanding the patient. After a dream is related the patient may ask the obvious 'What does it mean?' or 'Why did I dream that?' Rather than attempting a general answer based more on the interviewer's unconscious than the patient's, the interpretation or meaning of the manifest content to the one who had the dream should be sought.

Also events which occurred during the day which relate to the dream should be clarified, from this point, the era in the patient's life in which he was in contact with the characters in the dream should be explored.

In some instances a patient who has read widely but not too well in lay literature on psychology apparently ceases to dream due to a fear of his own interpretations. In others a failure to dream may be evidence of resistance.

A lady previously seen by three psychiatrists mentioned with some pride 'No one has ever been able to make me dream.'

When she was told it was no great matter whether she dreamed or not, she promptly had a dream and was equally insistent on knowing exactly "what her dream meant."

The attitude towards dreaming may offer an appraisal of the patient's attitude towards treatment. There may be a superficial demand for help which conceals a not too subtle effort to dominate the therapy. (Actually, the patient utilizes the tenacity of her symptoms to strengthen her ego, particularly if the therapist is trapped into defending his treatment.)

## FACTORS WHICH MAY INTERFERE WITH TREATMENT

### *Relationship with the Patient*

The physician should "be himself" during the interview, but his relationship with the patient in psychotherapy is restricted in certain distinct ways. First, the relationship is not maintained for the therapist's satisfaction, pleasure, or comfort. Therefore, there is never a need to interject his problems, experiences or opinions on nonprofessional matters into the interview. The therapist is interested, concerned, and aware but essentially he remains a stranger. A failure to keep his personal history (interesting though it may be) out of the discussion will impede the progress of treatment.

The physician's not being disturbed by what he hears is probably more beneficial than any intellectual reassurance or interpretation he may offer. The patient tests the therapist's tolerance of his guilt by presenting the least traumatic event first; if the listener is not disturbed, the patient can safely proceed to the next concern which is nearer the core of his anxiety. Unless the physician is aware of this process, he may begin reassuring the patient before the basic problem is described.

### *Premature Diagnosis*

The therapist may erroneously conclude within the first five minutes that he knows the source of the patient's difficulties. By the use of leading questions and the selection of appropriate fragments from the history, he may quickly substantiate his conclusions.

The procedure varies according to the therapist's background and convictions. If he is only partially oriented dynamically, the patient may be told immediately of his unexpressed hostility for one parent or the other or assured of his latent homosexuality. If such a therapist is organically oriented, he hardly needs to hear the history, since the diagnosis is obvious (all cases are typical) and he always has a new medication for the condition.

This is not psychotherapy. Sullivan's suggestion that such folks ought to go into the natural sciences rather than deal with human problems was well founded.

### *The Therapist's Conflicts*

Presumably, all therapists of whatever order or discipline are permanently homeostatic. They seemingly are as alert during the last hour as during the first, as awake after a heavy lunch as after a light breakfast, and as perceptive of motivation in the mute as in the verbose. Actually, therapists bear a striking resemblance to other people. They tire as easily, may even become drowsy, and (God forbid) may in a weak moment indulge in their own phantasies. They may even have conflicts of their own.

Physicians free of anxiety or hostility and immune to the irritations of the day certainly may exist, but they are rather infrequently encountered. Most men in practice share the difficulties of others in equal or greater measure but a physician must be able to put aside his personal problems for his greater responsibility to the patient. Psychotherapy requires a similar effort. Psychotherapy also demands the physician's attention for a much longer interval than most treatment procedures.

The therapist's conflicts may be transitory and unrelated to a particular patient. For instance, he may have worked late, have excessive worries with his family, or simply have a dyspeptic day. If the immediate difficulty is so disconcerting as to interfere with the treatment, both patient and physician will profit by his canceling the appointment until he is more able to listen without inner distraction.

If a physician has difficulty treating certain types of patients, he may follow Jung's advice and treat those who share his peculiarities.

It is worth noting that in the few reports on the results of psychotherapy, it is the therapist's personality and experience which are emphasized as important, rather than his particular discipline or method.

### ADVICE AND REASSURANCE

The patient may be extremely uncomfortable, with a very realistic concern over his prognosis and what he should or should not do between visits. Any advice offered should be brief and limited to the patient's questions.

The anxious patient may be unable to express his aggression or hostility, but he may certainly expend his energy in other directions. Unless physical complications contraindicate the suggestion, the patient should be encouraged to be as active as possible in whatever endeavor he chooses. The activity serves as a method of discharge of some of his tension and may at the same time increase his self-confidence.

### TERMINATING TREATMENT

After the patient has been evaluated and the chronicity of his illness has been determined, the physician should establish a realistic goal for his treatment. This is best accomplished by summarizing his impressions and plan of treatment in two or three paragraphs after he is thoroughly familiar with the problem.

Subsequent treatment should be directed towards this goal with the patient's independence being encouraged by less frequent interviews. The termination, like the beginning, should be a part of the plan of treatment. The door should also be left open with the advice that if the patient has further trouble he should return.

There are many patients seen in psychiatry, as in other areas of medicine, in whom an ideal and permanent solution or "cure" is not attainable; but these same individuals may go months or years without need of therapy. They may also obtain considerable relief from the fact that if they need help it will be available. Such patients do not require interminable psychotherapy any more than a well-controlled diabetic requires a weekly check on his status.

# 9

## *HYPNOSIS*

*Hypnoid State*  
    *Medical Hypnosis*  
    *Present Status of Hypnosis*  
*Induction of the Hypnotic State*  
*Hypnotherapy*  
    *Indications for Hypnosis*  
    *Hazards in Hypnosis*  
*Terminating the Hypnotic State*  
*Negative Suggestion*  
    *Method*  
    *Summary*

## *Hypnosis*

*"... There will have been a new turn in fashion's wheel, bringing back treatment by hypnotic suggestion just as it will bring back our grandmother's hats."—JANET*

Hypnosis can be defined as a state of increased suggestibility in which dissociation occurs.

### HYPNOID STATE

Bernheim described hypnotism "as the induction of a peculiar psychical condition which increases the susceptibility to suggestions." Breuer speaks of a hypnoid state and quotes Moebius as saying that in such states "some kind of vacancy of consciousness" occurs in which an emerging idea meets with no resistance from any other. Such a state may be brought about by hypnosis or may exist in hysteria. Breuer also notes that: "All powerful affects restrict association—the train of ideas. People become 'senseless' with anger or fright."

In hypnosis such a hypnoid state is induced. The patient's conscious is cleared of contradicting ideas and sensations by first fixing the subject's attention and then focusing his interest on sensations resembling sleep which inhibit a normal awareness and increase his availability to further suggestion. Pavlov considered hypnosis, like sleep, to result from cortical inhibition; Kubie and Margolin described the cause similarly as a focus of excitation with surrounding areas of inhibition.

Hypnosis and the occurrence of posthypnotic phenomena have been attributed to dissociation, the depth of the trance supposedly

corresponding to the degree of dissociation Hypnotism has also been regarded as a conditioned response

The influence of the prestige of the hypnotist has been emphasized, as well as the patient's willingness to subject himself masochistically to the suggestions of the hypnotist, provided these suggestions are within the individual's self-established concepts of propriety

White, Masserman and others have shown that the patient attempts to be the hypnotized person he presumes the hypnotist wants him to be Bernheim was less concerned over this aspect of the 'trance' and stated that the patient sometimes pretends that he is cheating or that he is trying to be obliging' The tendency to play a role conditioned by the operator was shown by Speyer and Stokvis in the difference in sexual phantasies produced by a subject when the hypnotist was first a female and later a male Sullivan commented on the hypnotized individual's ability to remember past events while in a trance whether such events had ever happened or not

### *Medical Hypnosis*

The prevailing psychiatric attitude toward hypnosis is one of skeptical tolerance As Masserman says, most students of hypnotism usually go through phases of disbelief, enthusiasm, and loss of interest, because they conclude that whatever can be achieved by hypnotism can be accomplished more advantageously using other methods

Also the hypnotic procedure has been objected to because the aroma of showmanship, mysticism the black cape, and magic gesture persist. Since Kraepelin's laudable efforts to orient psychiatry along the patterns of clinical medicine rather than philosophy, and Freud's demonstration that the patient could recall forgotten memories consciously as well as in a hypnotic trance, psychiatry has made little use of hypnotism

The prevailing concepts of therapy imply an active participation by the patient, as opposed to the more passive attitude advocated in the earlier therapy by suggestion Freud's emphasis on the patient's awareness of unconscious motivation led to suggestion



being considered a temporary and rather inferior type of treatment (in which neither the patient nor the therapist became aware of the cause of the difficulty)

In any treatment, whether it be some uniqueness in psychotherapy or a new somatic approach, the implication that an investigator's results are, at least partially, due to suggestion is more likely to be alienating than appreciated although suggestion is no doubt a factor in all forms of treatment \*

### *Present Status of Hypnosis*

However, the place of hypnosis in medical treatment has not yet been established. The clearest appraisal of this technique has been offered by Rosen. He states that the method may be learned in as short a time as 30 minutes so there is little reason to devote a whole course to it in medical school, but hypnosis should be taught in obstetrics or surgery where the technique might be used in producing analgesia or anesthesia.

Rosen, like others, sees little benefit from the traveling groups who teach techniques of induction with little concern for the underlying psychodynamics. He makes the essential point that patients are not treated 'by' hypnosis but 'under' hypnosis. Hypnotism, then, is a method of facilitating therapy, particularly short term therapy in selected emotionally ill patients.

The procedure in hypnosis has undergone a change, presently the patient is more active and the physician is more an understanding than an authoritative figure.

The use of hypnosis by physicians other than psychiatrists, in obstetrics, before surgery, and in the chronically somatically ill would certainly seem desirable since the patient may be relieved of considerable anxiety and dread whether he is ever gotten into a trance or not. If he is not unconsciously influenced, he will at least be consciously relieved of some of his fears of the unknown. Hypnosis may also offer the physician added insight and greater com-

\* A highly praised somatic procedure was tried with an outstanding lack of success. These very negative results were in time published. In an irate letter a contemporary more enthusiastic over the treatment stated that the method had been improperly used and the results reported were undoubtedly due to suggestion. The only plausible reply was "the results were too poor to be attributed to suggestion."

prehension of the motives of human behavior (which may persist even if his enthusiasm for hypnosis fades).

Finally, reality is not always ideal; the world's jaundice is not always in the patient's eye. People find themselves in situations which are chronically unpleasant and cannot be altered by any practical means; cancer and coronary occlusions, as well as phobias, do occur. Therefore, patients terminally ill, who may look to the physician for help in accepting the undeniable as well as relief from pain, may have their relief prolonged and their apprehension decreased by the judicious use of this method.

### INDUCTION OF THE HYPNOTIC STATE

Probably the least important element in inducing a hypnotic state is the particular method used in bringing it about. Esdaile repeatedly performed drastic surgical procedures during trances which he induced by merely passing his hands above the patient's body, breathing on his head, and occasionally pressing on the patient's epigastrium. In Calcutta, on July 30, 1845, he successfully produced a deep trance while separated from his subject by no less than 80 feet; this distance was so great that Dr. Esdaile relied on an opera glass to better study the condition of his subject.

This remarkable physician, who once referred to himself as "the best abused man in the world" also observed: "One person induces mesmeric symptoms by deranging the nervous equilibrium, another by means of squinting, a third by monotony of sensation—the same effects being produced by different processes. . . ." He writes that those who become addicted to their own particular procedure conclude: "Your way is not my way and therefore it is wrong"; this addiction to a personal method he attributed to "self-love."

Esdaile believed, as Mesmer, that some vital agent passed between the one doing the mesmerizing (that is, hypnotizing) and the subject; and infers this passage may be facilitated by the sweat and saliva of the operator. Those most easily influenced, those most submissive, have "the languid, listless air that characterizes functional debility of the nerves." He warns against the use of this method in the healthy "for any attempt to be better than 'well' is pretty sure to make one ill."

Esdaile also recognized that a true understanding of the altered states of consciousness was obscured by 'artificial difficulties'. These artificial difficulties he attributed in the main to the ignorance and presumption of man, his passion for the mysterious and marvelous, his powers of self delusion.

Bernheim, who was professor at Nancy, used the following technique to induce a hypnotic state: he first reassured the patient (and occasionally hypnotized one or two others in the patient's presence to acquaint him with the benefits of such treatment). He would next request the patient to look at him and think only of sleep while he suggested that the patient felt tired, that his eyes were getting heavier and would close. Some patients would immediately go into a hypnotic state; in others the process had to be repeated.

In patients who were rebellious, anxious, or said they could not sleep, Bernheim suggested only that they were drowsy and sleepy. He would command that they be calm and perfectly quiet, adding that this degree of suggestion might be beneficial. With each successive attempt he sought a more profound state, this he termed 'suggestive education'.

Presently advocated methods of induction are not too dissimilar from those of Bernheim. The patient is reassured, told to relax, and some form of visual fixation or hand levitation is used.

In visual fixation, the patient is seated comfortably and asked to look at some particular point or object. It is then repeatedly suggested that his eyes are becoming tired, his lids are heavy and that he is becoming sleepy. These suggestions are offered in a persuasive, convincing manner. When a new sensation is added the patient must be given time to appreciate what he is supposed to feel.

The tiredness and heaviness he feels in his eyes are suggested in the extremities. The patient is closely observed and spontaneous movements are incorporated in the physician's suggestions to increase further the patient's incorporation of what he feels into the hypnotic state. He may be told his eyes are too heavy to remain open and that he will sleep.

In hand levitation the patient is seated with his hands in his lap and, following a similar procedure, he is told that one of his hands will feel lighter and numb and will gradually become so light that

it will rise. As the hand returns to the patient's lap he will become much more deeply asleep.

Perhaps the most essential element in inducing a hypnotic state is the physician's own conviction of his ability to produce the condition. This will be evident in the tone of his voice and the assurance with which he proceeds. It must be remembered that the time required for the patient to experience or carry out a suggestion varies, and that a longer interval is to be anticipated in this condition than in the waking state.

Wolberg and Rosen have written excellent monographs on the utilization of hypnosis to facilitate psychotherapy.

### HYPNOTHERAPY

The method followed after a hypnotic state has been induced will depend on the purpose of the treatment, the diagnosis, the depth of the trance, and the patient's response.

When this technique is used as a part of somatic treatment (to produce an analgesia or anesthesia), after the procedure is completed an amnesia for the event may be suggested and the hypnotic state is terminated. In the treatment of those with problems of emotional origin, posthypnotic suggestion may be utilized to affect the removal of symptoms. Depending on the depth of the trance, automatic writing or drawing or techniques of visual imagery may be used.

In automatic writing the patient may have a pencil placed in his hand with the suggestion that shortly the hand will begin to write without his exercising any effort or control over it. The subject may be asked to visualize a play and describe what he observes. It must be remembered that if complex or "structured" situations are suggested, the patient must be allowed enough time to respond; and if a definite situation is suggested it must be sufficiently complete to permit the patient to react. Essentially these special techniques are only means by which the physician gains insight into the dynamic factors in the patient's personality.

During the hypnotic state it may be suggested to the patient that a symptom will cease to disturb him, but the conflicts which produce the symptom will continue to increase in intensity as he

becomes more relaxed or more deeply asleep. Depending on the material produced during the hypnotic state, the patient may be advised that on awakening he will recall all or specified parts of what he has produced. The physician may suggest an amnesia for the hypnotic session if he feels the patient is not ready to tolerate the material in his awareness. The method of suggesting the patient may remember or forget what he likes of what transpires during the trance seems the most logical, since this gives the therapist insight into the nature of the material the patient needs to repress and what his ego can tolerate.

### *Indications for Hypnosis*

Rosen's point that this method is suited to selected patients as a method of facilitating therapy should be re-emphasized. How these patients will be selected cannot be generally stated; the selection depends on the physician's evaluation of the patient and his ability to utilize this method. Patients who have succeeded in repressing their conflicts and their hostility but have persisting symptoms of emotional origin, who have difficulty establishing a satisfactory relationship with the physician, and are unable to verbalize during the interview, may be treated using hypnosis.

The patient who prides himself on a life free of conflicts, although he suffers from a headache that has been too much for all the doctors in the past, may be more quickly understood with the help of hypnosis. Similarly, the patient who speaks with great difficulty, and his opposite who converses with great intellectual facility about impersonal superficialities, may be treated much more rapidly using this method.

The obese, the heavy smoker, or the alcoholic may seek this painless solution to his particular excess. In the alcoholic the reason for his sudden decision to seek treatment is usually obvious, since some crisis in his family or occupation provokes the decision to seek help. However, the motivation in the obese, the nail biter, or the smoker is much less obvious. The reason 'why' an obese individual after years of being overweight, suddenly decides to do something about it may offer a great deal of insight into the emotional factors which contributed to the obesity in the first place.

Whether the individual's treatment is facilitated by hypnosis or not, the reason for any decision to endure the discomfort of altering an established pattern of behavior should be clarified. The probability of success or failure in the treatment of the alcoholic or the obese may also be indicated by a history of similar decisions in the past which have faded before the first discomfort which restraint imposed.

### *Hazards in Hypnosis*

The motivation of those patients who come seeking hypnosis is wisely considered at length before the method is tried. The hysterical female patient may present a hazard with her sexual phantasies or she may subsequently experience sensations or debility which are attributed to the treatment. The existence of paranoid trends would well be considered a contraindication for the use of this method.

Meares stresses perverse motivation in both patient and physician as a danger in hypnosis. He also cautions about the acute anxiety the patient may experience if he fails to carry out a posthypnotic suggestion. A problem may also arise with the patient who may spontaneously ventilate repressed material even though hypnotized for other reasons. Meares advocates the use of hypnosis in psychiatry to relieve symptoms due to habits that have become self-perpetuating, rather than those due to active conflicts.

### TERMINATING THE HYPNOTIC STATE

The problem of restoring the patient to wakefulness has seemingly become less difficult since verbal suggestion has replaced gestures. Esdaile found that terminating a trance could present quite a problem. He describes one case where the patient was duly revived "but, as often happens when the system is deeply affected, he fell back into the trance." The patient was made comfortable on a bed at 1:00 P.M. and at 11:00 A.M. the following day he was no less comfortable but had shown no signs of reviving. Volatile stimulants to the patient's nostrils, cold water on the body and poured into his eyes "from a height" was without effect; water poured into his mouth brought "a violent fit of spasmodic coughing" which led to his recovery.

The hypnotic state is ordinarily terminated by a suggested signal such as tapping on a desk, or counting from one to five during which the patient becomes more widely awake as the counting proceeds. It has been observed that the patient who is difficult to dehypnotize is comparable to the patient who in routine therapy is difficult to get out of the office after an interview is terminated.

The patient's reluctance to be dehypnotized may be utilized in treatment if the dynamics involved are understood. It has also been suggested that the patient who fails to respond to efforts to terminate the trance be allowed to sleep it off. When such a condition occurs it would appear unwise for the physician to become too vigorous (that is, anxious) in his efforts at termination, otherwise, the patient may subsequently control the interviews.\*

Instances where dehypnotism is a problem are infrequent, when they do occur the physician should attempt to clarify the purpose of the behavior. The patient's response to previous therapy may show a similar type of resistance to treatment.

### NEGATIVE SUGGESTION

In 1932, Pratt, Golden, and Rosenthal reported on the results of treatment of 110 cases of pain of psychic origin. Fifty-five cases were treated by infiltrating the involved area with novocaine and 83 per cent improved. In the remaining 55, the skin was punctured but novocaine was not injected and, although no direct verbal suggestion was used 93 per cent improved.

Golden later modified this procedure and used it repeatedly to relieve conversion symptoms in hysteria. He felt the effectiveness of the method depended on the patient's increased suggestibility which was evidenced by their having conversion symptoms. The second element was the physician's confidence in the procedure, which in turn influenced the patient.

\* Such an instance was observed during a routine interview with an hysterical girl where hypnosis was not being used. The patient suddenly became unresponsive, her pulse and respiration were not unusual and efforts to elevate her eyelids to examine the pupil were resisted, in contrast to her generally relaxed state.

When she did not respond to verbal suggestions she was told to rest and relax until the therapist returned from having a cup of coffee. Fifteen minutes later she had not moved and was told she appeared much more rested and seemed more awake. She shortly responded and there were no more similar episodes.

### *Method*

Golden termed this "negative suggestion" as opposed to the direct or "positive suggestions" given during the induction of a hypnotic state, or in an effort to relieve symptoms by posthypnotic suggestion. This procedure was also carried out in the waking state, with the patient becoming more alert rather than less aware.

The physician proceeds in this way. The patient's attention is focused on the involved area, whether it is pain or a paralysis. He is asked to state in detail what aggravates the pain or disability and to demonstrate to the physician what sort of activity makes it worse. At no time during this examination is any reassurance given, nor does the examiner infer he can in any way alter the loss of function or the pain. To further focus the patient's attention, the limits of the involved area may be marked on the skin.

The patient should become curious, anxious, or hostile—something is about to happen and he has no way of preparing for it since no anxiety-relieving reassurance has been given. His blood pressure and pulse are taken and his heart is checked with the usual degree of preoccupation (before injecting saline or novocaine).

The patient's pulse is checked again and a few injections are made in the involved area; while the injections are being made the patient is requested to watch the second hand on a watch and inform the physician at 15-second intervals. The pulse is taken again and it will usually be somewhat faster.

The patient is then requested to *try* to move the paralyzed part or to aggravate the pain which has been present for the past three years. If the patient states the pain is less severe but still exists or shows some return of function in the previously paralyzed extremity, then he is again requested to define where the remaining weakness is, and a second series of injections is given.

The patient is then asked again to *try* to exercise the involved part or to produce the pain. He is aided and encouraged in these efforts to re-establish the lost function. In a "complete" conversion in which the classical indifference to the symptom exists, a bout of acute anxiety or rather obvious hostility may be manifest toward the examiner. During the recent war, when the splints or other



supports were removed and the involved extremity moved in spite of the patient, the routine response was "What have you done to me!"

The permanency of the results depend on whether the conditions which produced the converted anxiety are still in existence. If the patient no longer has need of the symptom, relief should be permanent unless the patient is again confronted by a conflict. This method is applicable to those patients in whom posthypnotic suggestions are feasible as a means of symptom removal. This method of treatment is not a means of differentiating an organic etiology from functional cause.

### *Summary*

The effectiveness of *not reassuring* the patient and offering him no escape from the anxiety purposely created, except in the form of relief from his pain or disability, should be emphasized. A similar situation may well be created in the less histrionic atmosphere of the psychotherapeutic session if the physician will not interfere by interjecting an involved explanation or interpretation. There also seems a tendency, with age, for the therapist to substitute an omnipotent grunt for an involved interpretation.

# 10

## *SOCIOPATHIC PERSONALITY DISTURBANCE*

Sexual Deviation

*Etiology*

    Characteristics of Homosexuals

    Other Types of Sexual Deviation

        Fetishism

        Transvestism

*Exhibitionism*

    Sexual Psychopath Laws

Antisocial Reaction

Dyssocial Reaction

## *Sociopathic Personality Disturbance*

The difficulties individuals in this group have are most evident in their conflicts with society. They do not respond to the community's demands, and their failure to comply, at times, seems so deliberate and of such a nature as to assure their apprehension.

Before definitely placing a patient in this group, it should be ascertained that his antisocial behavior is not the product of an underlying and more primary illness. Such possibilities as mental defect, organic brain disease, or psychotic reaction should be ruled out.

### SEXUAL DEVIATION

Homosexuality is a condition in which the individual's erotic choice is a person of the same sex. This preference may be overt or latent. If it is overt, the individual is consciously aware of his homosexual desire whether he carries it to completion or not. In latent homosexuality, the drive is repressed and remains unconscious. Kinsey's data and other studies indicate that there are different degrees of overt homosexuality. At one extreme is the individual who is gratified only homosexually and at the other is the individual who is exclusively heterosexual. Between these extremes are those who have responded erotically to both sexes.

Freud stated that in addition to the homosexual's choice of a sexual object his physical characteristics and mental attitude (whether masculine or feminine) were also contributing factors.

The importance or prominence of these factors varied in different homosexuals.

Freud added that it was not for psychoanalysis to solve homosexuality but only to disclose the psychical mechanisms that lead to the object-choice. In his report on an analysis of a homosexual woman, he emphasized the following frequent obstacles to treatment. The patient was in no way ill, suffered from nothing in herself and had no complaint of her condition; there was no existing neurotic conflict to resolve, rather an attempt was made to convert one type of organization of genital sexuality into another.

Freud also noted these patients usually seek treatment as a result of external pressures, or to satisfy themselves that they have done everything possible to overcome their abnormality. They may then continue with their previous sexual choice with an easy conscience.

Freud's treatment was principally concerned with the removal of the restrictions to heterosexuality thereby permitting the patient more freedom in his object-choice. The results were stated to be of the same order as attempting to convert a heterosexual individual to a homosexual one.

Fenichel notes the difference in the sociopath's "compulsions" to carry out his aberrant behavior and the neurotic's compulsive activity. The neurotic feels forced to do something he does not like to do; and the sociopath is said to be forced to like something against his will. The impulse in the sociopath is experienced in the same way that the normal individual becomes aware of an instinctual impulse.\*

Both the heterosexual and homosexual probably follow fixed patterns in their sexual behavior. In any event, the routine manner in which the male carries out his sexual activity in marriage is a

\*In the individual who is exclusively homosexual and has no other outlet, a repetitive pattern of seeking satisfaction would be expected to evolve. The more marked his sexual drive and the more he attempted to abstain, the more compulsively would this pattern be followed. During his abstinent intervals, he would probably avoid situations which would increase his sexual tension as he attempted consciously to control his impulse to satisfaction. Superficially, this would resemble the phobic patient's attempt to avoid anxiety producing situations or the compulsive's efforts to dissipate his anxiety by ritual.

frequent complaint by the wife. From the data offered, it would appear the male homosexual is frequently more interested in finding an outlet than in establishing an affective relationship.

The homosexual is much more vulnerable to frustration since his activity is not accepted by the community; partners are not so readily available and, if his sexual preference becomes generally known, his personal security and his social acceptance may be threatened.

### *Etiology*

Factors listed as explanatory of the homosexual object choice in the male include: an intense mother fixation, an Oedipus love for the mother, castration anxiety and fear of female genitals (that is, being without a penis), and identification with the mother (with a desire for a similar method of sexual gratification).

Fenichel names two etiological factors to be considered in the female homosexual: the castration complex initiating a repulsion from heterosexuality; and an attraction through early fixation on the mother which serves to protect and reassure. As a result of disappointment over the Oedipus wish, the female homosexual may identify with the father and assume an active masculine relation with other women.

partner was a sexual outlet. Fourteen per cent of the group were scoutmasters who had had relations with boys under their supervision.

Ross and Mendelsohn studied homosexual college students and found little difference between the homosexuals and others, in academic characteristics. Undergraduate female homosexuals had a higher grade average than other female undergraduates.

Kallman's findings in male twins is of interest. The incidence of concordance as to overt homosexual experience in fraternal twins was 40 per cent, which approximates the occurrence in the general population. On the other hand, concordance as to homosexual experience was noted in 44 pairs of one-egg twins.

Kinsey reported an increased frequency of homosexual experience in the single female until by age 45 approximately 28 per cent reported such an experience. Among females the overt contact leading to orgasm was only a third of that found among males.

### *Other Types of Sexual Deviation*

#### FETISHISM

This is the endowment by a male of an object with genital meaning. This symbol then becomes a source of erotic gratification, and relieves both psychic and sexual tension. This may be a girl's pants or shoe, or any other article associated with a female that has particular erotic meaning to the individual. The analytical explanation has been that the patient is unable to accept the physical differences between the sexes, the symbol becoming a "female penis."

#### TRANSVESTISM

Transvestism is a morbid desire to dress in the clothes of the opposite sex. As Noyes and Kolb mention, the explanations for this deviation "are still largely speculative." The dynamics given relate again to the inability to account for the female's lack of a penis, the transvestite representing the phallic woman.

This desire may or may not be associated with exhibitionism.

Female impersonators continue to be quite an attraction for the normal. In other instances the transvestite may dress secretly in his wife's clothing, taking great care to conceal his abnormal impulse from others.

A 24-year-old, rather obese, effeminate male was referred after telling his general practitioner he was not sure whether he was male or female. He had been passively and contentedly homosexual since his adolescence. He had recently dressed in woman's clothes as a joke but found that he was readily accepted as a female. He enjoyed both the attention and the fact that he was deceiving the male. The patient was not aware of having any trouble; he merely wanted to know if what he was doing "was all right."

#### EXHIBITIONISM

This is a very common type of sexual deviation in which the inadequate male attempts to reassure and gratify himself by exposing his penis to women. The exhibitionist must startle or produce fear or his self-confidence will be even further diminished.

The choice of subjects to whom the exhibitionist exposes himself varies. The individual's inadequacy may require that he restrict his efforts to small girls, and he will therefore frequent areas near schools. Others, less selective, may choose subway stations. There has been remarkably little psychiatric interest in the traumatic effects of such episodes on the children or women the exhibitionist disturbs for reassurance.

#### *Sexual Psychopath Laws*

The public's concern over deviant sexual behavior, particularly those offenses involving children, led in 1937 to the passage of the first "sexual psychopath laws." Bowman and Engle made a detailed study of the history and development of these laws. They found that in recent years such legislation has been enacted to protect the public more adequately and prevent future offenses.

In addition, there is presently more effort to obtain help for those who are treatable and provision for continuing confinement for those still dangerous to the community. Bowman pointed out



that recidivism in this group is only 7 per cent. There is an erroneous idea that any hospital staff or board can predict with 100 per cent accuracy which patient will repeat an antisocial act. This tends to make the responsible individual hesitant to discharge a patient.

Recently the laws make a clearer distinction between the socially distasteful and the socially dangerous sexual offender. The more the particular type of sexual deviation practiced by the individual offends or endangers others in the community, the more infrequently will he be able to obtain satisfaction. The greater his tension before he repeats the act, the greater the violence may be with which he carries it out.

Differences in legal definition, indictment procedure, and enforcement make it difficult to determine the national incidence, although Kinsey's findings and other similar data indicate that only a fifth of such offenses are reported to the police.

### ANTISOCIAL REACTION

The most apparent abnormality in this group is the failure of the future consequences of their actions to modify their present behavior. The restraint which concern for the future normally exerts does not deter them. These patients seemingly live in the immediate, at the mercy of the impulse of the moment.

Previously a patient in this group was termed "psychopathic personality" or "constitutional psychopath." The individual realizes the wrongness of his act but does it anyway, much of his behavior appears more impulsive than pleasurable. The aggression may be lacking in purpose, and the individual can give no reason for his senseless crime. Characteristically, he is not too concerned over the act, the punishment or the fact it was done without purpose.

It may be presumed that most behavior is controlled by some future goal, even if this goal is no more distant than the next meal nor any more exalted than the choice of the place where it will be eaten. Some selectivity in response and control of impulse normally prevails. The combination of excessive aggression without restraint or any goal beyond the satisfaction of an impulse makes such an individual a hazard in any group or community.

Being unbound by loyalty or responsibility, and profiting neither from punishment nor experience, his life may be marked by episodes of violence. The behavior is rationalized as warranted and therefore justified, and remorse is not apparent. The lack of concern over punishment would follow the individual's lack of a goal. Since he had no particular goal which the punishment would prevent his attaining, punishment would only be unpleasant as it prevented his satisfying the impulse of the moment of his aggression, or would be physically painful.

This behavior has been considered an acting out of unconscious conflicts, hate or love. The aggressor remains unaware of his unconscious motivation.

In others the aggression is less evident. They may be attractive, charming and malicious. Such people are extremely adept at appearing as others would have them be. As one such individual remarked, 'Everybody in the hospital is trying to save me and that's just fine.' They may lie pathologically, the tales being wishfulfilling phantasies.

One such patient was seen at age 23. He began to steal from purses when he was 6 or 7 years of age, at about the same time he would "run away" if left alone. He was treated for a prolonged period in a child guidance clinic and showed some improvement in behavior.

He socialized poorly, was of superior intelligence and in his teens began to break and enter. This soon became a rather fixed pattern. He would walk about in a residential area in the evening with increasing excitement until he selected a house to enter. If there was a question of the occupants being in, he would ring the doorbell; if they answered, he would apologize for having the wrong address and leave. If no one answered, he would force a window and enter the house.

He would immediately locate the master bedroom to determine whether anything of value was at hand. If there was a library he might select an appealing volume to take with him (on one occasion he was arrested because a public library book he had previously checked out was found in a house he burglarized). He might enter more than one house in an evening.

When seen his record included more than two pages of single spaced typewritten charges. He had been in three different reform schools and two state penitentiaries. His charm presented hazards at times; once when he was sent to a reform school he reported the following conversa-

tion with the warden: "I've been in before and usually I'm given a job in the library, and this is fine. But in about 6 weeks you'll leave a car somewhere and I'll run off. Then you'll send me to the 'State Pen'. This I want to avoid."

The warden told him he knew how to run his institution and dismissed him. However, two weeks later he was working in the library and during the third week he took a truck, left the school and was shortly captured. In six weeks he was in the "State Pen"—"just like I told that jerk warden when I got there," he added.

A very pleasant 36-year-old male forger volunteered for a drug experiment which involved some hazard. When asked why he volunteered, he readily answered "the monotony." This was his second felony conviction in this particular state. He had periodically gone on check-forging sprees during most of his adult life, eleven years of which he had spent in prison.

He followed a pattern, but he was equally aware of the "compulsive" behavior shown by the normal individual. For instance, an establishment which displayed a sign saying "No checks cashed here" indicated the owner had previously accepted a worthless check and would in all probability be ready to accept another. This prisoner said he always dressed well and made it a point to buy some item which the owner obviously wanted to get rid of. He said it was amazing how many "honest" people would try to cheat him by raising the price on the item. He said he never objected, he just made the forged check out for a little more.

### DYSSOCIAL REACTION

Those in this category are less in individual conflict with society than the patient with an antisocial reaction. They comply with the patterns of the particular group of which they are a part and to which they may have a marked loyalty. The deviations of behavior and personality which they demonstrate are usually not individual but are common to their group. Their deviation from the cultural mores may be in the form of participation in organized crime which attempts to keep the scope of its operation obscure and unidentified. Such a group not only has its deviant loyalty but a system of punishment for those failing to comply.

Those showing this type of reaction may have lived in an environment in which the moral and social codes were abnormal as com-

pared to those generally held. It would seem most difficult to generalize on moral codes, particularly as they relate to sexual morality. Essentially, the abnormality of the behavior shown by any group would have to be measured against the prevailing standards of the population from which the group is drawn.

Other groups expend a great deal of effort merely exhibiting the fact that they are disregarding the social codes and attempting to avoid obscurity. These groups usually originate as a protest or rebellion against something. This is most often a rebellion against the pointlessness or monotony of community life and its innumerable commonplace realities.

Actually, it is the individual's fear of losing his identity in the uniformity of the contented which forms his protest. Lacking this contentment, he joins with others who are similarly inclined and attempts to induce the community to share his disturbance and be saved from their lethargy. Usually the manner in which such a protesting group breaks with the patterns of the community is not too disturbing. They may ridicule prevailing standards or fail to conform by showing peculiarity in dress (beards, berets and bare feet), this helps the conforming members of society and tourists identify them.

They are usually very vocal in advocating sexual promiscuity which seems to attract members and nonmembers alike. To determine whether they are actually sexually more promiscuous or merely more vocal, would require more controlled study. Depending on the generation with which they are not complying, such groups may be called bohemian or 'beat'.

# 11

## ALCOHOLISM

The Problem

Definition

Etiology

Types of Alcoholics

Passive Alcoholics

Aggressive Alcoholics

Female Alcoholics

Pathological Intoxication

*Conditions Secondary to Dietary Deficiency*

Korsakoffs Psychosis

Wernicke Syndrome

Treatment

Medical Management following a Bout

Physical Treatment

Metabolism of Alcohol

Controlling the Delirium

Suggestion in Delirium Tremens

Withdrawal Symptoms and Alcohol Addiction

Somatic Treatment

*Conditioning Treatment*

Treatment with Sensitizing Drugs

Alcoholics Anonymous

Problems in Treatment

Course of the Illness

The Alcoholic in Industry

Management of the Alcoholic in the State Hospital

## *Alcoholism*

Community Approach to the Problem  
Education and Information Center  
Outpatient Clinic for Alcoholics

## THE PROBLEM

The fact that there are four million or more people in the country who are only one drink away from an alcoholic bout qualifies this affliction as a major problem. Approximately every tenth patient admitted to a mental hospital is an alcoholic who becomes a psychiatric responsibility.

However, alcoholism is above all a chronic illness with an average duration of 10 to 15 years before treatment is sought or accepted. During these years of excess, families, other employees, and the neighborhood may be directly affected by the patient's drinking. In this culture males are affected approximately six times as frequently as females, and the pattern of excessive drinking is usually established by age 25, although the problem may not become obvious until the individual is between 30 and 35 years of age.

## DEFINITION

Any individual who requires alcohol to meet the ordinary demands of living, or continues to drink excessively after alcohol has repeatedly caused him marital or occupational difficulty is an alcoholic.

## ETIOLOGY

Before attempting to establish the etiology of an illness, ordinarily agreement is first sought that such an illness exists. The

American Medical Association answered this by saying that alcoholism represents a deviation from a state of health, and as such is a medical illness. In addition to being a deviation from a state of health, an illness should be characterized by a group of signs or symptoms occurring together which make it recognizable. Finally, it should have a natural course which is typically self-limiting, or recurring or chronic if untreated.

It seems reasonable to state that alcoholism is a chronic illness which may be rapidly progressive or may stabilize, but is usually characterized by remissions and exacerbations. The most obvious effects of alcoholism are psychological and social; pathomonically, the alcoholic does not decrease his intake as his drinking causes him trouble, but increases the amount he drinks as his excess creates new problems.

The first obscure area in this illness is the time of onset—when does the patient become alcoholic? Are there prodromal symptoms unrecognized but existing long before the first drink is taken? This brings up the old question: Is the alcoholic an alcoholic before he takes the first drink? It might be postulated that the alcoholic drinks for internal reasons which are either developing or are in existence before he takes his first drink. Whether these postulated internal differences result from a combination of genetic and nutritional factors (Williams) or from psychic elements is not yet clear.

There is clarity in one area: the alcoholic becomes addicted (or at least habituated) to a substance which is not addicting to the non-alcoholic; 70 million drink socially but only 4 million have a problem. If the etiology of alcoholism can be explained as a slowly developing addiction in which some metabolic alteration occurs that requires alcohol as a source of energy, this dependence is not accompanied by an increased tolerance. Careful studies have failed to show an increased ability to oxidize alcohol in the chronic patient as opposed to the social drinker. In fact, after a patient's liver is severely damaged his individual tolerance is reduced. He may not reduce his intake, but he will be comatose longer on the same amount of alcohol.

Efforts to determine the etiology of this illness are complicated by the fact that the psychiatrist seldom sees or recognizes the alco-



holic at the beginning of his disorder. He is usually treated for the complications of his drinking only after years of an excessive intake. If this condition is considered a chronic illness which is extremely insidious in its onset, which is caused by persisting and as yet unalterable factors, then, like aging, the etiological agents will have to be sought in youth rather than in the examinations of the terminal changes as seen in the "skid row" patient.

On the other hand, alcoholism may not be a primary disorder but one which results from the physical, psychological, and social changes secondary to the prolonged intake of alcohol in toxic quantities. The question could be raised: Is this a distinct group or would anyone who drank with equal vigor for a long enough time show these same changes regardless of his infantile experiences, the adequacy of his liver, and the strength of his ego when he began.

There are almost as many theories as to why people become alcoholics as there are types of alcoholics. They are described as belonging in various psychiatric diagnostic groups, although little is said about the vast majority of patients in these same psychiatric groups who do not become alcoholics. For instance, if it is concluded alcoholics are neurotic, what prevents all but a very few neurotics from becoming alcoholics? Too, why should Jewish people, who are not free of emotional illness, be comparatively free of alcoholism, an immunity that the Irish do not share.

Alcoholics frequently seem to have less concern or worry over themselves and their difficulties than persons with emotional problems that are uncomplicated by excessive drinking. In fact, alcoholics may even look on a recent severe illness due to excessive drinking as a revelation and make such statements as, "I've learned my lesson," etc., until it is felt that this conviction of knowledge (often relearned) may be so strong that it may lead to more drinking to mark the discovery.

Various attempts have been made to explain the alcoholic's difficulties on the basis of their personalities. A great deal has been said about the role of latent homosexuality and oral eroticism in the etiology of chronic alcoholism. It is true that men frequently drink in the presence of other men, but the choice is limited only to two sexes, and the fact that men as a rule are more tolerant toward

drunken behavior than are women is likely to be of some weight in determining the alcoholic's choice of drinking companions. One study of these patients failed to show any greater frequency of homosexual responses than were found in normals.

There is little doubt that orality is a factor in some; as an example, an abstinent alcoholic drinks three or four cokes while a less oral and more anal character is having one. Others chew cigars during their waking hours or continuously light cigarettes; but similar behavior may be seen in the obese who have never had a problem with alcohol, or in the overactive individual who is neither obese nor alcoholic. Furthermore, in considering the factor of "oral eroticism," one is forced to admit that most of the alcohol ingested enters the human body via the mouth; yet here again the choice of routes is limited (Flemming).

Recently the feminizing changes seen in some chronic male alcoholics, in which gynecomastia, a loss of axillary, chest, and pubic hair, and impotence occurred, was attributed to the patient's inability to conjugate his own estrogen. In the subprimates, this conjugation occurs primarily in the liver. Recent work shows that in a male alcoholic with liver disease, 80 per cent of externally administered estrogen is excreted in the urine. This finding makes the previous explanation somewhat less tenable.

Williams' genotrophic theory presumes the alcoholic has either an increased need for vitamins or other essential nutrients, or an inability to utilize satisfactorily what he consumes in an ordinary diet. Williams has described the nutritional needs of these patients in detail in a recent monograph. There is little doubt about the requirement of vitamins in the treatment of the chronic alcoholic. This is due to the deficiency imposed by an inadequate diet, and possibly the increased need created by the excessive amount of alcohol he metabolizes. Whether this need is any more specific than the other inadequacies in his diet (a lack of the essential amino acids, and essential fatty acids and minerals) might be questioned.

### TYPES OF ALCOHOLICS

Persons with sociopathic personality disorders, schizophrenic reactions, and manic-depressive reactions, as well as those who are

mentally defective, may drink excessively as a reflection of underlying psychopathology

There is no one personality type typical of the alcoholic. Many do not develop the ordinary neurotic defenses, but rely instead on alcohol to control their anxieties. Therefore, attempts to place alcoholics in diagnostic groups frequently reveal a sizeable number of "normal" alcoholics. Lemere states that the only characteristic alcoholics have in common is the fact "they drink too much." Bowman notes that neither personality traits nor educational attainments differentiate the alcoholic from the nonalcoholic.

On the basis of their behavior while not drinking, alcoholics may be described as passive or aggressive in their relationships with other people.

### *Passive Alcoholics*

The passive group is characterized by an inability to express hostility or anger; they are too considerate of other people and thereby vulnerable to imposition. They dislike disharmony and argument and conceal the anger and resentment they feel over small slights. They are well liked and their family friends, and not infrequently their employers are protective toward them. This attitude in turn fosters dependence in the patient.

Their lack of self-confidence demands the use of alcohol to overcome a fear of failure when any new task is attempted, but the drink they take to overcome their fear repeatedly assures their failure. When sober, they may be continuously dissatisfied with themselves and what they have failed to accomplish. Their goals for themselves may be grandiose as compared to their abilities or too near perfection to allow accomplishment. As a result, they are regularly unhappy.

In some instances such patients are almost infantile in their lack of self-reliance. The wife or family, after years of hope and disappointment, attempts to keep them under constant surveillance, to allow them only enough money for carfare or lunch, and in essence to deprive the patient of all responsibility. In an extreme situation the only satisfaction such a patient experiences arises from the alco-

hol he drinks, and his efforts at overcoming the obstacles that prevent his obtaining it.

As an example, a very attractive though socially shy girl married an aggressive, domineering individual. She was immediately faced with an increasing number of obligations.

She found that alcohol relieved her concern over the responsibilities, and she would 'take a couple' before they went out or before her guests arrived. Five years after her marriage the drinks she took to get ready to go out would frequently prevent her going; or soon after she arrived she would be stuporous. The following day she experienced extreme guilt over her behavior. At first, she agreed her husband's criticism was justified. Gradually, this guilt was projected and the husband was blamed for all her drinking. He would berate her and she would not reply until the next bout and then systematically deny all his accusations.

Eight years after the marriage they had ceased to 'go out' socially. The husband attempted to hide the liquor from her and she in turn hid a bottle from him. Whenever he left town she promptly drank herself into a comatose state. His solution was to hire a maid to stay with her at all times to be sure she did not set the house on fire with a cigaret. Periodically her drinking would be interrupted by a brief visit to a hospital.

### *Aggressive Alcoholics*

The aggressive group have an unusual amount of energy, drive and physical stamina. They are inclined to continue and to "overdo" any activity, including drinking, until they are exhausted or comatose. Before the fourth or fifth decade of life, they show unusual recuperative powers and are able to recover rapidly after a bout of drinking.

As they grow older, the intervals between the drinking episodes shorten as they gradually lose their tolerance to alcohol, and on routine physical examination they may show an unexplained enlargement of the liver. The ability and drive these men possess frequently result in their being quite valuable to their firms and attaining positions of great responsibility.

A 44 year-old executive gives the following history. He had always been a successful salesman. Most of his customers expected him to drink

with them and they were rarely disappointed. Everyone he knew socially drank and like to party. He had always been able to play cards and drink all night and bounce back the following morning.

Three years previously he ran his car off the road and was arrested for driving while intoxicated. At about the same time he began to have episodes of amnesia (that is blackouts) when he drank. He would have a few in the afternoon and the evening would be a blank.

In spite of his drinking he had been most able in his business and held a responsible position. He would occasionally take a couple of drinks in the morning to get started after a hard night.

The alcohol at times made him irritable and belligerent. He could no longer take three or four drinks without the effects being noticeable. He was seen after the firm which employed him demanded he either accept treatment or be discharged.

### *The Female Alcoholic*

The female alcoholic's excessive drinking is perhaps a more serious break with her cultural group than is similar behavior in the male. It seems likely that the female is more apt and more able to conceal her drinking than the male. The housewife begins her drinking after the husband leaves for work and revives in time to prepare the evening meal.

A female alcoholic's decreased awareness and impaired judgment may encourage sexual promiscuity and unlike the male alcohol does not interfere with her ability to perform sexually. Some inhibited female (as well as male) alcoholics may initiate a bout with the goal of releasing sexual tension. This would appear to be the exception.

Most married female alcoholics utilize the privacy their homes afford to drink themselves into oblivion in a not too dramatic fashion. A particular excess may coincide with a husband's trip out of town. Undoubtedly some female alcoholics have an excessive sexual drive and seek after masochistic pleasures and perverse acts with the same avidness some nonalcoholic females do but such behavior is not typical of the alcoholic woman.

A female alcoholic's sexual encounters are more likely to depend on chance than any deliberate or planned effort on the patient's part. As the alcoholism progresses all other interests become secondary as the following demonstrates.

An attractive 36 year-old female, who was severely alcoholic, found herself without any beer during a bout which occurred during her husband's absence from the city. She ordered more beer but when it failed to arrive promptly she became impatient and went to a nearby 'drive in' to pick some up.

She bought the beer and decided to have a 'couple' in the car to steady her nerves. While having a third or fourth bottle of beer she was approached by a 'friendly' stranger who eventually drove her home.

She vaguely recalled his driving her back and his getting her a beer after they arrived. She thought she undressed herself, when she woke up he was gone and so was all the beer. She did not recall having had intercourse, nor anything else that happened during that six or seven hours.

### *Pathological Intoxication*

This is an abnormal response to a relatively small amount of alcohol. The individual is so unstable that he is not capable of functioning coherently after taking alcohol. The behavior shown may be aggressive, lacking in purpose, and destructive. There is usually an amnesia for the episode.

### CONDITIONS SECONDARY TO DIETARY DEFICIENCY

The following conditions, Korsakoff's psychosis and Wernicke syndrome, are associated with a deficiency of the B complex vitamins and thiamine in particular. They are less frequently seen now than in the past and are related to the chronic alcoholic's prolonged malnourished state. Treatment consists of giving the B complex vitamins in large doses, and correcting the patient's dehydration and malnutrition.

#### *Korsakoff's Psychosis*

In this condition the alcoholic is disoriented and has severe memory defects which he attempts to conceal by fabricating events which never occurred. The fabrications may be forgotten as rapidly as they are produced and the same question repeated may bring forth a new set of answers. A peripheral neuritis is usually found.

In contrast to patients with delirium tremens, those with a Korsakoff's psychosis are seldom apprehensive, show little concern over

their state, and may assume a joking attitude about their deficiencies and the questions they attempt to evade. A Korsakoff's psychosis occurs more frequently in women than men.

The condition usually improves over a period of a few weeks although residual defects may persist. These defects may be sufficiently extensive that a permanent impairment of mental function is evident particularly in the older alcoholic.

### *Wernicke Syndrome*

This syndrome results from a thiamine deficiency and lesions occur in the grey matter of the brain stem in the region of the third and fourth ventricles (acute hemorrhagic polioencephalitis superior). The onset is usually during an episode of delirium, the first evidence may be an ophthalmoplegia, an ataxia, or a hyperpyrexia.

A 54 year-old alcoholic was admitted in a state of delirium. He was dehydrated and malnourished. During the evening he was noticed to be ataxic, a bilateral ptosis was present and his temperature was 101°. He was given large doses of thiamine to which he slowly responded.

## TREATMENT

### *Medical Management following a Bout*

The degree of toxicity in the patient will be roughly proportionate to the duration of the alcoholic bout, the inadequacy of his diet during the bout, and the amount of alcohol consumed. The patient's age and his physical state before he started the bout are of equal importance in determining the effects of the above factors.

Treatment consists of correcting the physiological changes which have occurred, and of decreasing the patient's discomfort during recovery. These ends are not accomplished by giving any one vitamin, hormone, tranquilizer, or sedative.

The systemic dehydration, the malnourished state, and the electrolyte imbalance are in immediate need of correction. If the patient is vomiting or has a diarrhea the toxic state will be aggravated. Frequently the patient gives a history of increasing food intolerance as the bout progressed until he could retain only alcohol. Finally the day came when he could no longer retain alcohol. When this

occurs, the patient is extremely toxic, agitated, unable to sleep, and may show clouding of his sensorium (that is, a state of incipient delirium). If the incipient delirium is not treated or if the patient is vomiting he may pass within a matter of hours into a state of active delirium.

#### PHYSICAL TREATMENT

The dehydration is overcome by giving a liter of 5 per cent glucose in a balanced electrolyte solution intravenously; this is followed in four to six hours by a second liter of glucose in saline. Food and liquids should be given by mouth as tolerated. *The B complex vitamins and ascorbic acid should be added to the intravenous solutions; later they should be given orally.*

The diet should be high in carbohydrate and protein with sufficient fat to supply the essential fatty acids. Although adequate methionine and choline may be available in the patient's diet, these lipotropic agents would still seem indicated during the first week of treatment.

The amount of Bromsulphalein retained is perhaps the best available method of evaluating improvement in liver function. If the patient can be kept in bed and inactive, this improvement will occur more rapidly.

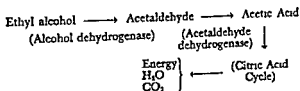
Varying amounts of liver damage may be present and may account for much of the patient's fatigue and exhaustion which he attempts to relieve with alcohol. The pancreas may also be involved after a bout or following the ingestion of large quantities of alcohol. Unfortunately, this may be first suspected at the post mortem examination.

#### METABOLISM OF ALCOHOL

Ethyl alcohol enters the circulation rapidly and unchanged, from the stomach and intestinal tract, following ingestion. The rate of absorption is delayed by fat and protein.

Alcohol is apparently principally metabolized according to Scheme I.





SCHEME I

The rate at which alcohol is metabolized is fairly constant (approximately one ounce of whiskey per hour) although there may be considerable variation in individual tolerance. It has been shown that the level of alcohol does not rise as rapidly in the cerebrospinal fluid as in the blood nor does it drop as rapidly as the alcohol is detoxified. The metabolism of alcohol occurs primarily in the liver.

Westerfeld and his associates and Pletscher and co-workers have shown that fructose, given either orally or intravenously, increased the rate of disappearance of alcohol from the blood by 50 to 70 per cent. (The most available source of fructose is honey.) Thyroid and heat would presumably increase the destruction of alcohol by increasing the rate of metabolism in general.

The effects of insulin on the rate of metabolism of alcohol is controversial, but the increase is due to an increased rate of metabolism of carbohydrate rather than a direct effect on the alcohol. Therefore, if insulin is used in treatment, it should be given with carbohydrate. Fasting or an inadequate diet decreases the rate at which alcohol is metabolized.

#### CONTROLLING THE DELIRIUM

The first consideration is the frequency with which grand mal seizures occur (15 per cent in one series) in chronic patients following an alcoholic bout. These 'rum fits,' or alcoholic epilepsy are related directly to the drinking. An anticonvulsant such as a long acting barbiturate is indicated. Mephobarbital (Mebaral) is such a compound which is not habit forming and may be continued after recovery for its tension relieving properties.

The tranquilizers may be used according to the physician's preference, chlorpromazine (Thorazine) is as effective as any introduced to date. The jaundice occasionally reported following the

administration of phenothiazine derivatives does not appear to contraindicate their use in the alcoholic. Short-acting and medium-acting barbiturates should not be used because of their habituating properties, the amount required to effectively control the agitation, and the existing liver damage.

Delirium tremens appear to be a self-limiting toxic state which follows a prolonged alcoholic bout. If the patient's physiological abnormalities are corrected and alcohol is withheld, the delirium should clear within 12 to 18 hours.

The necessity of a careful physical and neurological examination for these patients cannot be over-emphasized. A delirium which persists beyond this period or an increasingly stuporous state demands more than "watchful waiting." Head injury should be suspected and the spinal fluid should be checked for evidence of increased pressure and hemorrhage; roentgenograms of the skull should also be obtained.

Since 1937 it has not been fashionable to dehydrate these patients further following admission, although previous to that date they were purged, fluids were restricted, and hypertonic solutions were given intravenously.

#### SUGGESTION IN DELIRIUM TREMENS

The delirious patient has many illusory experiences (misinterpretation of stimuli) which may involve any of the special senses. "Seeing things" is perhaps the most frequent but the patient is able to combine his misinterpretations into a "complex illusion" to which he responds. For instance, a delirious patient hears an imaginary phone ring; he not only hears it, he sees the phone, picks it up, answers the call (which is always for him) and carries on a conversation. He then replaces the receiver and returns the phone carefully to a nonexistent table. This is done with such conviction that the group making rounds ceases talking until he hangs up.

The inability to determine the source and meaning of stimuli makes the patient exceedingly suggestible; for instance, if asked to, the patient may be able to read printing on a blank wall. This same suggestibility makes the individual responsive to the many types of treatment recommended in the care of such patients. It

follows that the patient will also respond to reassurance and may be terrorized by restraint or isolation

The delirious patient may be in a state of panic, he may be perspiring profusely have a marked tachycardia and be frightened by every sound or flash of light. He will frequently misidentify the interviewer Too the delirium may be imposed on an underlying manic depressed or paranoid state which will persist after the acute confusion clears

#### WITHDRAWAL SYMPTOMS AND ALCOHOL ADDICTION

The controversy over the need to taper off the alcoholic after a drinking bout as opposed to an abrupt withdrawal of all alcohol continues and as a corollary the existence of a delirium of abstinence is still held by some However reports of the development of delirium in as high as 75 per cent of such patients while they were still drinking the increased psychological dependence that the medical use of alcohol may produce in the patient the aggravation of existing pathological conditions and the availability of other less toxic drugs—all of these militate for an abrupt and total withdrawal of all alcohol

It may be worth pointing out that the person who is not an alcoholic develops a toxic state accompanied by anorexia nausea vomiting tachycardia profuse perspiration and dehydration after an excessive intake of alcohol (that is a hangover) However the nonalcoholic successfully controls the toxic state by abstaining from the use of alcohol whereas the alcoholic perpetuates the toxic condition by taking more alcohol to relieve the symptoms Many chronic alcoholics continuously attempt to taper off this is evidenced by their tendency to buy only half pints of alcohol because they feel that is all they will need to stop drinking

Since a tolerance to alcohol beyond the variations explainable on the basis of individual differences is not demonstrable and alcohol is apparently metabolized at a rather fixed rate in the chronic and in the nonalcoholic there would seem to be little basis for presuming a physiological addiction Whatever innate tolerance the alcoholic possessed when his liver was intact will probably be decreased as his liver damage increases Young alcoholics may tolerate

a quart of whiskey a day in their early thirties but after ten years of diligent drinking there is no evidence that their enzyme systems have been sufficiently altered to allow their doubling this intake.

### *Somatic Treatment*

#### CONDITIONING TREATMENT

By giving an emetic along with alcohol, the unpleasant sensations, the nausea, and the vomiting become associated with the sight, smell, and taste of alcohol. The reaction is repeated during six or seven daily sessions while the patient is hospitalized. He is then asked to return at four to twelve week intervals for six or seven additional treatments. The following year a re-enforcement of the conditioning process every three to four months is recommended.

When emetine hydrochloride is used as the emetic, Kattwinkel advises that an electrocardiogram be obtained before, during, and two weeks after the treatment. Those with cardiac damage would be considered poor candidates for this type of treatment due to the hazards of developing a toxic myocarditis following the use of the emetine hydrochloride.

#### TREATMENT WITH SENSITIZING DRUGS

In 1948 a method of treatment which interfered with the metabolism of alcohol was introduced. Disulfiram (Antabuse) inhibits the enzyme (acetaldehyde dehydrogenase) which oxidizes acetaldehyde to acetic acid. Acetaldehyde accumulates very rapidly and unpleasant and frightening reactions occur.

Within two to ten minutes the patient's conjunctiva become injected, his face flushes, his respiration becomes rapid and labored, and he develops a "pounding" headache. There is frequently a marked drop in blood pressure with a tachycardia, the systolic pressure may drop to below 60 mm. Hg and the diastolic reading may not be obtainable by auscultation. A state of "acetaldehyde shock" may ensue and the patient may appear cyanotic.

He may also be nauseated and vomit; the patient is quite apprehensive and may complain of substernal oppression or shortness of breath. Transitory changes in the electrocardiogram have been

reported After 30 to 45 minutes the patient may become drowsy and sleep for an hour or longer The cardiovascular effects and the flushing slowly subside The patient may have a slight headache and feel "hung over" for the remainder of the day

The reaction may be modified or terminated with intravenous antihistamines The patient is 'sensitized' (that is will have a reaction if he drinks) after taking four grams The maintenance dose is from 0.5 to 0.25 grams daily The medication must be continued if it is not taken the patient can drink without a reaction in from 7 to 14 days after the last dose

Calcium carbimide (Temposil) which was introduced in 1956 produces a similar type of reaction The advantage of this compound is the lack of severe cardiovascular effects when the patient drinks This compound does not contain sulfur and therefore does not produce the objectionable odor to the breath and perspiration caused by disulfiram No complaints of lethargy, drowsiness or impotence were heard from 94 patients given this drug

The only undesirable quality that calcium carbimide has is the rapidity with which it is excreted Unlike disulfiram the patient may skip the medication one day and drink the next Just how great a disadvantage this is would be open to question, since the advantage provided by the delay disulfiram imposes between the last pill and the first drink is probably outweighed by the excuses the side effects provide for discontinuing the medication The dosage of calcium carbimide (Temposil) is one or two 50-mg tablets daily The patient is usually sensitized within three to four hours after the first tablet is taken

### *Alcoholics Anonymous*

This is a group made up of alcoholics whose only purpose is to help those with similar problems They offer understanding and interest and are a nondrinking group with whom the patient can become identified This organization has helped a great many alcoholics to maintain sobriety The physician should familiarize himself with Alcoholics Anonymous by attending one of their open meetings, where he will be welcome

### *Problems in Treatment*

Several factors make treatment of the alcoholic a very difficult procedure.

The greatest and least emphasized problem is the patient's reluctance to accept the diagnosis, and therefore the treatment which prohibits his drinking.\* It must be realized that whatever originally motivated the drinking is not altered by alcohol, and continuously confronts the patient during his sober moments. Too, he has found an answer to his discomfort; although it is an unsatisfactory solution, it is still one which affords temporary relief.

In addition, there are the added problems which a prolonged reliance on alcohol brings, such as financial and social loss, doubt of his sincerity by wife and employer, and the ever present, ever available relief no farther away than a bottle, hidden for just such an emergency.

Of no lesser consequence in continued drinking is habit, established over a period of years and become so routine that promises to abstain are not motivated from within but are merely rituals repeated to placate the demands of others. Those treating alcoholics too often see the patient as he might be rather than as he is—a mistake the family may have made consistently since the day he took his first drink.

### COURSE OF THE ILLNESS

The question whether an alcoholic is such before he takes the first drink is an area not yet dulled by agreement. There are probably degrees of susceptibility; at one extreme is the individual who begins drinking in his late teens, fails to mature, lives at home under the protection of an aggressive mother and a passive father, and is severely alcoholic by his early twenties.

In essence, such an individual remains emotionally infantile although physically mature, since he accepts no responsibility for self or others; depending on the finances and tolerance of the family for his behavior, he either rapidly arrives on "skid row" or

\* One alcoholic who apparently did not understand the purpose of his treatment with disulfiram, when asked why he had quit taking his medication answered: "Why those pills made me sick every time I drank."

soon begins a series of admissions to private hospitals. Such patients are not too concerned by what means oblivion is obtained, they take "nonbeverage" alcohol (canned heat, shaving lotion, etc.), barbiturates, or narcotics as they are available.

At the other extreme is the individual who for physical and psychological reasons has a low tolerance to alcohol and through the persuasion of others, by occupation, or by social chance he becomes involved with a group who drinks excessively. They drink so he drinks, but he may lack the tolerance and control the others have.

This is the individual who has lunch with a group who has "a couple" of martinis before lunch, and "a couple" after work, and maybe "two or three" before dinner. Over the weekend, he is with a "drinking group" and a considerable amount of alcohol is consumed during the two-day stretch.

Monday is not a very good day; the residual of the weekend decreases his efficiency but he usually manages to make an appearance. He maintains sufficient control of his drinking to avoid occupational or social disaster. Such an individual is in that indistinct area between mild alcoholism and heavy social drinking.

Between these extremes are the majority of alcoholics who early in their drinking careers, or from the first drink, show peculiarities which predict their course.

Alcoholics drink for many reasons, but perhaps with a common goal—to decrease their state of awareness. The more severe alcoholic quickly reaches the endpoint of oblivion. Such a side effect as "gulping drinks" on the sly probably is no more than an alcoholic compromise, to avoid attracting the attention of those already concerned about his drinking, by the quantity he consumes. There is no doubt alcohol affords the chronic patient relief. The fact that the relief is temporary and extremely destructive does not appear to be considered.

Many social drinkers "have a couple" before attending a social function about which they are apprehensive or when, because of previous experience, they anticipate a dull evening. They differ markedly from the alcoholic in their behavior after they arrive. The nonalcoholic drinks for the stimulation which results from

a decrease in his self-imposed inhibitions, for an increased ease of sociability, or for relief of fatigue after a hard day, but he does not deviate markedly or frequently from the pattern accepted by his cultural group. He does not become stuporous, burn a hole in the rug, or blister his fingers with a cigarette due to his decreased awareness.

It is most unlikely he will ever be arrested for driving while intoxicated; the consequence of his behavior is dimmed but not obliterated by the alcohol. In the nonalcoholic the alcohol is secondary to other activity; but in the alcoholic drinking becomes primary, an end in itself; it replaces socializing.

The rationalizations indulged in by the alcoholic tend to increase the severity of his problem; since every drink is to be the last, he always makes it exceedingly adequate. Finally, the chronicity of this disability must be re-emphasized; not only the patient but the entire family is chronically involved. Over the years, his drinking is discussed, dreaded, and awaited; it happens so regularly that finally the drink that initiates a bout sets off a ritual of behavior in the family as well as the patient. Some members deride the patient in his stupor; others attempt to defend him; some avoid him or keep out of his sight until he is again sober.

During his intervals of sobriety he is a consistent source of anxiety or hostility and may rightfully feel that the whole family "watches every move he makes" as they await the fateful day when the next bout begins. He may have "sworn off" so regularly that they have committed his protestations of future sobriety to memory and may aid him if he forgets or falters in his expressed determination.

### THE ALCOHOLIC IN INDUSTRY

Since alcoholism is an illness of adults which is most marked during the productive years and is approximately six times as frequent in men as in women, any industry having a sizeable group of employees will have the problem to consider. The individual involved is as likely to be a vice-president as someone in maintenance. It has been previously pointed out that the alcoholic employee has one pathognomonic bit of behavior, since his is the only disability most likely to be manifest on Monday.



The employer's approach to the alcoholic should be as practical and free of bias as circumstances allow. The management of and decisions regarding the alcoholic employee should be based on his particular problem, and not on the personal feeling of the one charged with helping him.

It is wrong to conclude that because an employee has a problem with alcohol he is the same as all other similarly ill people or that his diagnosis makes him untreatable. Alcoholism as any other illness must be evaluated individually as to its severity; however, like an infectious illness, the alcoholic's condition may jeopardize others who work with him; this requires restrictions and limitations other disabilities do not impose.

In no other illness is an evaluation of the patient more necessary because, regardless of the duration of the drinking, the previous attitude of the patient and the frequency with which he has failed in the past, the possibility remains that he may successfully abstain. He should have the choice of seeking treatment from his own physician or, if he desires, the company should furnish him with information as to where help may be obtained. This information should include both medical and nonmedical assistance.

The employer can only make treatment available to the alcoholic who desires and will accept it. He can increase the motivation for sobriety by requiring the alcoholic's successful cooperation if he is to continue in his job. Unless the patient is convinced of the need to abstain and of his inability to take a single drink, then the best that can be hoped for is a little more prolonged interval between bouts.

An organization should have a clearly stated and fixed employment policy regarding the management of the problem drinker. This policy has to consider both the employee and the employer since an unending tolerance of intoxication in an individual is harmful to the alcoholic and to the morale of other employees; it is incompatible with the efficient working of any organization.

At the same time, it must be appreciated that the step from drunkenness to total sobriety is not an easy one and that one or two slips are to be expected, but that two or three is the maximum that practicality allows. Too, if the alcoholic employee is aware

that this is the policy of the organization and not merely a personalized threat for his benefit, he will be more apt to accept the necessity for sobriety.

The greater the responsibility of the job the alcoholic employee holds, the greater the need for impartial enforcement of the policy, since to be tolerant of intoxication at one level and intolerant at another cannot but create justified resentment.

It is wise to have those responsible for the alcoholic acquaint themselves with the problem by reading the available literature, and if possible to have them attend a clinic where such patients are treated so that they may have an opportunity to learn firsthand a practical approach to the problem.

This method of education is far more desirable than giving this responsibility to an individual who already has fixed, positive, and unchangeable opinions about "all" alcoholics, based on his own previous personal experience. This individual may have had an alcoholic, improvident father at whom he is still angry—not the most desirable qualification for helping an employee with uncontrolled drinking.

Above all else the one responsible for the alcoholic must have common sense and controlled enthusiasm. He must not show too much elation over the patient's sobriety, nor become depressed if he "slips." It must be appreciated that although the alcoholic can certainly be treated, the motivation and desire for help must exist within the patient and his behavior must remain his own responsibility.

There can be no compromise with the need for total abstinence. There can be no "cutting down," or "social drinking"; the alcoholic must be continuously sober or in the process of getting drunk. Therefore, administratively, the fact must be stressed that sobriety must become a permanent and not a temporary state for the employee.

Depending on the size of the organization, the following suggestions are made.

1. Factual and readable information on alcoholism prepared for the laity is obtainable and should be made available to all employees; any inquiries should be held in confidence.

2 If a nurse or physician is not employed, an interested individual in the personnel department should become acquainted with the secretary of the local Committee on Alcoholism if one exists, and with one or more members of Alcoholics Anonymous this individual should frankly discuss the situation with the alcoholic employee, advise him (or her) of the company's policy and put the alcoholic in contact with a member of one of the above-named organizations. The person charged with the responsibility of the alcoholic should also have a list of physicians who are interested in the problem and want to work with these patients.

3 If medical personnel are available, some one individual (physician or nurse) should be assigned the responsibility and should make an effort not only to familiarize himself with the medical aspects of alcoholism but also should be encouraged personally to investigate the available treatment facilities and become acquainted with members of Alcoholics Anonymous to be certain where and to whom the employee is referred.

4 If the company employs a physician he may treat the alcoholic after a physical examination by giving him disulfiram or calcium carbimide. Either of these preparations taken regularly will immediately make the alcoholic ill if he drinks. Granted the reaction may be severe, but the only difference between being sick after drinking while taking a sensitizing drug and being sick after a bout is that with the 'sensitizing' drug it is quicker but certainly no more hazardous.

### MANAGEMENT OF THE ALCOHOLIC IN THE STATE HOSPITAL

The group of alcoholics with which the community is most familiar are the residents of skid row who enter the endless treadmill of arrest (or commitment), release drunkenness and re-arrest. They are an expensive group to a city a discouraging group in treatment, and perhaps represent the public's impression of "all" alcoholics.

The first problem with this group is legal if they refuse treatment they can only be managed in a controlled environment (that is, either a jail or hospital). Since every tenth admission to a

mental hospital is an alcoholic (it sometimes seems every tenth admission is the same alcoholic since some have been admitted as many as 20 times), they are an enduring problem for the state hospital

Since the likelihood of the state hospitals' responsibility suddenly ceasing as a treatment source for the chronic alcoholic is remote, the following is suggested as a plan of management

If possible, a particular hospital ward should be designated for the treatment of alcoholics. The patient should have a complete physical and neurological examination as soon as possible after admission. This should be an "open" ward. Those who depart against advice (that is, elope or escape) should be returned to a "closed" section of the hospital (in one state hospital the escapes decreased from 27 to 4 during a comparable period of time after the ward was unlocked). All the patients desiring to work at regular assignments in various parts of the hospital should be allowed to do so. Group and individual therapy should be carried out as often as personnel permits. Somatic therapy such as the sensitizing drugs (calcium carbimide or disulfiram) or aversion treatment should be part of the treatment routine.

The patients should be admitted for a minimum of 60 to 90 days. This prevents the physician in charge having to persuade each new admission of his need to stay in the hospital. This is also a realistic interval during which treatment can be initiated and the drinking pattern at least briefly interrupted.

A scheduled program should be worked out with Alcoholics Anonymous and meetings should be held on the ward. Those interested should be encouraged to attend.

Those judged clinically able should be allowed a weekend at home at the end of the first month, two weeks before discharge the patient should be permitted to leave the hospital during the day to seek employment.

Those patients with organic deterioration, those who are of borderline intelligence or defectives, and the schizophrenics should be screened out and managed according to their basic illness. Those who have no interest in being rehabilitated should be kept for longer periods with each admission.

If a patient cannot exist outside a controlled environment this fact has to be accepted and considered in treatment. There is no profit to the patient in being briefly discharged, briefly sober, and quickly returned

### COMMUNITY APPROACH TO THE PROBLEM

Alcoholism, like infectious disease, is a threat to others besides the patient. Unlike any other illness it is manifest as an exaggeration of a widely accepted social custom. Attempts to control the alcoholic by prohibiting the social drinking of the population of which the patient happens to be a member have not provided a solution.

The problem is further complicated by the alcoholic's reluctance to accept the diagnosis and his legal right to refuse treatment, as one alcoholic attorney remarked: "it was his 'inalienable right to drink' if he saw fit. If the alcoholic's behavior is sufficiently disturbing he may be arrested or committed, but in either event, the alcoholic and the community are faced with the same problem from the moment he is released."

Until further knowledge about these patients is obtained, even a partial solution requires a realistic appraisal of the problems of the different types of chronic alcoholics present in the community.

#### *Education and Information Center*

The lay public needs to be educated regarding the nature and course of this illness. This information should be unbiased, factual, and repeatedly presented. A local committee on alcoholism should be established with an advisory group composed of representatives of organizations concerned with the management of these patients (county medical society, Alcoholics Anonymous, labor and management, church, welfare) and prominent civic-minded individuals from the area.

In addition to this advisory group a working committee with the most able organizer available as chairman should set definite concrete goals to be accomplished with a minimum of 'fanfare or publicity'. An 'information center' to advise the families of alcoholics about the help available, with a paid secretary and an

office should be established. Once this "information center" is established, it should be accepted as an agency of the community fund.

### *Outpatient Clinic for Alcoholics*

An information center on alcoholism needs an outpatient alcoholic clinic to which patients who desire treatment may be referred. In addition, a list of physicians who will accept these patients should be obtained from the county medical society as a referral source for the secretary of the clinic.

The alcoholic outpatient clinic should be established in a general hospital where medical consultation is available. Not more than one patient in twelve who will accept treatment for his alcoholism requires hospitalization. Those 5 to 8 per cent who do require inpatient treatment, who will accept it and who are co-operative, should be treated in general hospitals. The outpatient clinic should serve a second function as a follow-up facility for the discharged patient, particularly those receiving "sensitizing" drugs or other medication over a prolonged period.

*AFFECTIVE REACTIONS*

- History
- Etiology
  - Heredity
  - Body Habitus
  - Observations on Occurrence
- Depression—Psychoanalytic Theories
  - Freud
    - Summary
  - Abraham
- Depression
  - Clinical Description
    - Appearance
    - Presenting Complaints
    - Somatic Complaints
  - Thought Content in Depression
  - Evaluating the Degree of Depression
  - Suicide
- Mania
  - Hypomania
  - Manic
- Types of Affective Disorders
  - Involuntional Psychotic Reaction
    - Clinical Description
  - Manic-Depressive Reactions
    - Manic Type

## *Affective Reactions*

Depressed Type  
Other Types  
Psychotic Depressive Reaction



These are psychotic reactions characterized by disorders of mood which are primary and severe. The thinking is disturbed but is appropriate to the altered mood.

## HISTORY

From the time of Hippocrates, sustained and abnormal changes in the moods of men have been observed and recorded. Hippocrates and Galen attributed states of mental depression to an excess of "black-bile" (*that is, melancholia*). Those so troubled were later said to be "with deep melancholy" or having a "pensive sadness."

In 1790 Fischer pointed out that to understand melancholia the chronological development as well as the presenting complaint must be appreciated. Borrow in 1828 stated that mania and melancholia were of the same origin, and Allen in 1837 regarded both states as resulting from "the same power being overactive in different directions."

Falret in 1855 described "circular insanity" in which a tendency to paroxysms and remissions was characteristic. This illness was said to be curable in its attacks but not in its essence. He based this classification on "a collection of characteristics related together and following a definite course." Baillarger in 1854 described the same types of cases as "*folie à double forme*."

Kahlbaum in 1882 stated the symptoms seen in mania and depression were different stages of the same illness. He named the

milder forms of shorter duration 'cyclothymia', the more protracted and severe forms, "insania typica circularis"

Kraepelin in 1896 called these periodic disturbances of mood a manic-depressive psychosis. He stated that periodic or circular insanity and simple mania were but different phases of a single morbid process and reported that the different phases might occur in the same patient. Kraepelin also pointed out that even though these disorders frequently recurred during the life of the patient there was not a progression to a deteriorated state.

In 1934 Lewis published two refreshingly well-organized and comprehensive papers on depressive states, one a historical review and the other a clinical survey. Both papers emphasize the difficulties of classification and the lack of accord as to what is reactive and what endogenous. He adds that a sharp distinction for the sake of 'academic accuracy' is without benefit 'when the distinction is not found in nature and is no help to thought or action'. Hoche (1910) is quoted in the same vein, 'our subjective need is no proof of the reality of that which we desire' in seeking after pure types for purposes of diagnosis.

### ETIOLOGY

The nature of the manic-depressive reactions remains as obscure today as when Kraepelin complained of the inadequacy of the prevailing hypotheses in 1902. No characteristic anatomical or metabolic change is demonstrable in these patients. However, the results of empirical treatment have been more encouraging with these illnesses than with the other psychotic reactions of unknown etiology.

#### *Heredity*

The frequency of these disorders in certain families and in twins has led to an hereditary predisposition being considered of marked etiological importance. The incidence of such a predisposition in 60 per cent or more of these patients has been reported.

The studies of monozygotic twins by Kallman, Rosanoff, and others have shown a very high incidence of concordance (70 per cent or higher) as compared to dizygotic (17 per cent) and the general population.

*Body Habitus*

Kretschmer stated that those patients with a pyknic habitus (middle height, rounded figure, broad face, short massive neck, fat paunch with a vaulted chest) were more prone to develop this type of illness. He characterized these people as sociable, good natured, friendly, genial, cheerful, easily depressed, and softhearted.

Sheldon, using more exact methods of measuring and statistical procedures, evaluated photographs of normal individuals. His fat mesomorphs or individuals with a mixture of endomorphy and mesomorphy compare with Kretschmer's pyknic group.

*Observation on Occurrence*

Kraepelin remarked on the adequate intellectual endowment of these patients, and Myerson described the frequency of such disorders in prominent American families. The affective disorders are reportedly twice as frequent in women as men, higher in Jewish than non-Jewish patients, and four times as prevalent in professional groups as in the general public.

## DEPRESSION—PSYCHOANALYTIC THEORIES

*Freud*

Freud compared grief with melancholia and clarified their similarities and differences. In mourning the loss is conscious and the individual maintains his self-esteem; in contrast to melancholia, in which there is an 'unconscious loss of a love object' and a loss of self-esteem.

Freud pointed out that in grief, although the loss is conscious, 'man never willingly abandons a libido-position' and only slowly relinquishes the lost object as the work of mourning proceeds. It is further stressed that an object is slowly invested with libido over a period of time, and following the object's loss reality's demand for acceptance of the loss is not quickly deferred to. Each memory and hope that bound the libido to the object has to be gradually released bit by bit. This protracted work of mourning is extremely painful but 'this pain seems natural to us'.

In melancholia the libido has to be freed similarly from the unconscious loss and this, too, is a prolonged, painful procedure. 'If

the object has not this great significance, strengthened by a thousand links to the ego, the loss of it would be no meet cause for either mourning or melancholia."

Three conditioning factors were postulated as necessary for the development of melancholia: loss of the object, ambivalence, and regression of the libido into the ego. The loss of esteem, self-vilification, or "delusional belittling" seen in melancholia appeared to be directed more at an object than at self. Freud stated the object at whom the self criticism was directed was a person "whom the patient loves, has loved, or ought to love." This loved object, having been lost, is re-established in the ego by the "substitution of identification for object-love." "Thus the shadow of the object fell upon the ego.

The libido with which the lost object was invested regresses into the ego to avoid annihilation. The ego attempts to incorporate the object and make it part of self, as in the manner relied upon in the oral stage of development (the earliest form of identification).

Besides the libido which "regresses to identification" another portion, as a result of the "conflict of ambivalence," is reduced to sadism. Therefore, the thoughts of suicide shown by those depressed are murderous impulses "against others redirected upon self."

Following the introjection of the lost object the ego is divided or is "fallen into two pieces." The ego ideal—the individual's critical-faculty or conscience (which is attributed to superior powers or individuals, particularly the parents)—derides the lost-object in the ego. This derision is consciously experienced as self-criticism.

#### SUMMARY

In normal grief a conscious loss of a love object occurs; a loss of self-esteem does not occur. The work of mourning is the reliving or freeing of the libido with which the lost object was invested.

In melancholia an unconscious love object is lost, and a marked loss of self-esteem occurs. The lost object is reestablished in the ego and the ambivalent feeling is expressed by self-criticism of the ego by the ego-ideal.

*Abraham*

Abraham's observations on character development are based on the following conclusion: "Those elements of infantile sexuality which are excluded from participation in the sexual life of the adult individual undergo, in part, a transformation into certain character traits."

He emphasized that the oral components of infantile sexuality required less modification and sublimation in the adult than those of anal origin. Furthermore, the transformations of character observed in nervous disorders seldom reflect a regression beyond the later developed anal stage. If the disorder is of such a degree that regression to a more infantile level occurs, both oral and anal traits are found.

In an infant, sucking fulfils the functions of nutrition and pleasure; Abraham pointed out that one source of pleasure is only relinquished as another is made available. As the pleasurable qualities of sucking decrease, the act of biting is substituted, and weaning is begun as toilet training is initiated. In toilet training, the pleasure of retention is offered in substitution for the satisfaction of expulsion.

Undue gratification or frustration, at any stage of infantile sexual development, was postulated to cause an increased demand for gratification in the next succeeding stage, either in an effort to prolong the excess or to compensate for the lack of satisfaction. A child with this background was said to regress more easily to a previous stage.

Abraham added that "those traits, which belong to the clinical phenomena of the anal character, are built up on the ruins of an oral eroticism whose development has miscarried." A failure to progress satisfactorily through the infantile stages interferes with the development of a necessary balance among the pleasures of retaining, giving, and acquiring in the adult. A failure to develop such a balance may leave the ambivalence of emotional life unresolved, or an exaggeration of some one of these pleasures may lead to persisting traits of character.

Abraham compares the pleasure of retention in the infant to

the mental satisfaction of possessing objects in the adults; with this undue pleasure in possession there occurs an unnatural fear of loss.

If the entire character is under "oral influence" the individual shows a prevailing optimism, but is likely to presume a "mother substitute will always appear to assure his satisfaction"; this belief breeds dependence and inactivity. On the other hand, the melancholy pessimist only seems to be an anal character, since the difficulty began with a deprivation in the oral stage. This oral deprivation subsequently produces in the adult the following character traits: an exaggerated seeking after security and protection against loss. Such traits are attempts to avoid re-experiencing the deprivation of the oral stage.

A lack of gratification during the sucking (pre-ambivalent) period was also said to produce the following type of adult: one who clings to other people and is forever in need or asking for something; such individuals are further characterized as being impatient, taking without giving, or "clinging like leeches." Others so afflicted attempt to give as they hope to gain, that is orally, and are overtalkative and orally aggressive, substituting talk for a sadistic wish to bite.

An oral character (gratified) is described as being generous, bright, and sociable, receptive to new impressions and ideas and accepting of change. The source of his character traits is revealed by a "morbid appetite" and an inclination to oral perversity. (According to Kinsey's data, oral perversity is less rare than frequent.)

Individuals showing characteristics of the oral sadistic stage are inclined to envy and jealousy, to expressed hostility, and to maliciousness. It follows that sociability is not an outstanding quality in this group.

Abraham's comments on those who displaced their infantile sucking instincts and became scientists are of interest. He noted that such individuals should be able to digest as well as consume information and should not expel the products of their oral needs too rapidly. It is said that "such people have no sooner taken a thing in than it comes out of their mouths again." It might be added that the undigested may also appear in one's bibliography.

He noted that the manic depressive patient during his free-interval (*that is* between episodes) showed a character formation similar to the obsessional neurotic. Those inclined to melancholy are ambivalent before they become depressed but during the depressed phase an equal amount of ambivalence involves their own ego. Ambivalent conflict was said to begin during the oral sadistic (biting) stage of infantile development.

The choice of neurosis in a particular patient who becomes depressed requires the existence of the following factors

- 1 An over accentuation of oral erotism as a result of constitutional and inherited factors
- 2 A fixation of the libido at the oral level
- 3 A severe injury to infantile narcissism as a result of repeated disappointments in love
- 4 The occurrence of the first disappointment before the Oedipus wishes have been overcome
- 5 A repetition of the primary disappointment in later life (The repetition of the primary loss in an adult is seen as the precipitating event in a depressive episode)

Abraham explains the self-criticism seen in depressions as arising either from (1) the original love objects having been introjected and having been the base upon which the patient's ego ideal was built this ego ideal takes over his conscience and the criticism of self emanates from this fault finding object or (2) the criticism of self being in reality a reproach of the introjected object

## DEPRESSION

Since depressive reactions are frequently seen and not always easily recognized a brief clinical description of such states seems fitting before classifying the different types

Meyer suggested in 1904 that the term melancholia be abandoned in favor of depression for these types of illnesses and that a further distinction could be made according to the intrinsic nature of the depression. This is followed in our present classification

## *Clinical Description*

### APPEARANCE

Those depressed have a sad, worried, anxious, or concerned expression. They appear weighted-down, overcome, and either resigned or apprehensive. Cameron pointed out the decreased spontaneous movement shown by such patients. They are less likely to finger objects, to "doodle," to lean back and relax in a chair than those not depressed. Associated movements are decreased, the patient walks without vigor, his stride is limited, and it requires longer for him to perform routine tasks.

He has few comments to make; there is an absence of small talk, and his conversation is limited to topics of concern. The patient is dominated by a persisting unpleasant mood, his gloom is evident, and there is a pathological variation in his affect.

### PRESENTING COMPLAINTS

The presenting complaint may be quite vague—the patient saying, "I don't know what's happened to me but something is wrong, I don't enjoy anything anymore," or he may simply say, "I've slowed down, I can't get anything done, I have to make myself do everything." As Lewis pointed out, hours of controversy may produce little academic accord as to the meaning of emotion or affect, but the plain man has little doubt as to the meaning of the question, "How do you feel?" The depressed patient's reply to this question is usually "Miserable," "Terrible," "Hopeless," "No good," or some similar expression of dejection.

He may complain of his loss of self-confidence and express ideas of worthlessness. He may be unable to make up his mind; this indecisiveness may be nearly immobilizing. A housewife cannot decide what dress to wear; when she shops she no sooner makes a purchase than she returns it. Her housework is overwhelming. She spends the day trying to decide which routine task to attempt first. Similarly, a very able surgical resident in his third year of training decides he has entered the wrong profession and that he is not capable of operating.



## SOMATIC COMPLAINTS

Those depressed fail to gain pleasure from their activities, satisfaction in accomplishment is lost. Anorexia is a usual finding, the smell or sight of food produces nausea rather than hunger, they eat mechanically without pleasure. They have an enduring fatigue unrelieved by rest and aggravated by effort. Activities previously automatic have to be forced, routine is overwhelming, the minutiae of everyday living become endless tasks. Janet added that a fear of action was "an essential element in the sentiment of melancholia."

Occasionally, a depressed patient will complain of some one physical complaint such as muscular pains and aching or fatigue and weakness, without much emphasis on his disorder of mood.

As an example, a 38 year-old male would cross his arms on his chest, clasp each shoulder with the opposite hand and walk the floor, complaining of the persistent aching that he experienced. He was seen in two different clinics where exhaustive physical studies failed to reveal a basis for his discomfort. However, the patient's history revealed that at age 18 he had spent 10 months in bed at home with a diagnosis of 'chronic tonsillitis and sinus trouble'. Again at age 27, he was unable to work for over a year because of fatigue and 'chills', on this occasion he was diagnosed as having "brucellosis".

When he was seen with his muscular pain, he had received 22 electric shock treatments without benefit. He gradually recovered with supportive psychotherapy given in the "right" phase of his illness (during his period of recovery). He remained asymptomatic for six years and then developed vague lower abdominal and genito-urinary complaints which did not respond to treatment but by which he was again totally incapacitated.

Sexually, the male first loses interest and may later become impotent, the female has first a decreased ability to respond sexually with a lack of interest which soon becomes a marked aversion. The lack of pleasure and gratification from all activity includes that of a sexual nature.

Sleeplessness is a frequent problem. Insomnia is enhanced by the patient's morbid thoughts which increase his wakefulness. The added fear of the aggravation of his despondency following sleep

may cause the patient to dread a night's rest. Characteristically, there is a diurnal variation in mood, with the depression being most marked in the morning and lifting somewhat as the day goes on. Freud commented on this as follows: "The amelioration in the condition that is regularly noticeable towards evening is probably due to a somatic factor and not explicable psychologically."

The morning exaggeration of the depression is probably related to sleep rather than the hour of the day, since if the patient takes a 'nap' in the afternoon this sleep may be followed by a similar increase in symptoms. During recovery the patient may have a good day and feel like 'his old self again,' only to wake the following morning again depressed, discouraged, and hopeless.

Along with the loss of ego or self-esteem, a patient's aggression decreases as the depression deepens. The husband of a patient who had had several depressive episodes could predict the onset of an illness by the change in his wife's bidding at bridge. Between depressions she bid aggressively, this ceased when she became ill, and shortly she would be unable to make up her mind and would become too indecisive to play.

### *Thought Content in Depression*

The thought content is appropriate to the patient's mood. Kraepelin pointed out the decrease in associations which occurs in the depressed patient and the necessity of a deliberate effort of will to continue thinking. These two factors result in a slowing of thought and speech. It has also been stated that the slowness in association was selective—the more affect involved the greater the retardation, whereas impersonal happenings could be recounted without an equivalent degree of slowing.

The slowness of thought and action (that is, psychomotor retardation) has been postulated to result from a deficiency of psychic energy or intrapsychic hypofunction. Patients complain that they cannot concentrate or collect their thoughts. Others say, 'I can't stop thinking about myself,' or their thoughts are too awful to repeat.

Those who become depressed have been called 'obsessive characters' or 'oral characters' or described as being merely 'sensi-

tive" They frequently have unpleasant ideas which continually force their way into the patient's consciousness against his will, as obsessions do

Delmar observed that a melancholic state 'rests on anxiety', he defines anxiety as a 'harmful mental state concerned with harm to come' Anxiety and depression are usually both evident in the patient, and the predominant symptoms determine the diagnosis In those archaic descriptive days of the past, it was not unusual to find a depression initiated by a bout of acute anxiety

In addition to his obsessive thoughts the depressed patient may complain of being changed or of having feelings of 'depersonalization' The patient may say he no longer 'has any feelings' or that he 'feels dead or unnatural' Others describe feelings of unreality related primarily to their environment—'things seem changed around, everything is different, it's like I was somebody else watching myself', 'nothing looks the same to me anymore I dread being around people and don't enjoy anything I used to like people'

In the severely ill somatic delusions may be prominent, the patient says his intestines are 'rotting away', he has 'turned to concrete and is all stopped up', he has a loathsome and incurable disease which is just cause for other people's shunning him The patient may express delusions of persecution but, as has been pointed out, although he is a victim of his persecution he is a "guilty victim" and merits what he is receiving Hallucinations may occur, particularly if a toxic state is imposed on the underlying depression

### *Evaluating the Degree of Depression*

In evaluating the severity of a depression, Lessing's observation that 'politeness and decorum forbid screaming and tears and demand a more passive fortitude, should be kept in mind The more integrated the patient the more successfully he may conceal his misery and the more unexpected his suicide may be to family and physician

The patient may fear hospitalization and shock treatment and attempt to minimize the depth of his despondency to avoid or forestall either What is more hazardous he may conclude the only

possible help is psychiatric and if this help is not immediately forthcoming he may give an appearance of improvement and if allowed to leave the hospital on a visit may carry out a previous decision to suicide

### *Suicide*

Suicide may be the first and last symptom of a depression, studies of attempted suicides indicate that less than 10 per cent have been seen by a psychiatrist and a large percentage have not appeared previously in need of such care

Henderson and Gillespie comment on the rapidity of recovery from depression in those who attempt suicide, and the seemingly trivial nature of many provoking incidents that precede such efforts. Suicides among adolescents receive such publicity in the lay press that an exaggerated impression of their frequency may result. When suicide does occur in the adolescent it is usually an impulsive act, motivated by anger at a parent, disappointment in love, or fear of punishment

Mayer Gross points out that efforts at destruction of self without evident motivation begin to appear following puberty and may be the first obvious symptom of schizophrenia

A 19 year-old girl who had only been regarded by her family as 'quite religious,' threw herself into a trash fire she was tending. She was mortally burned and only survived a few days, but prior to her death she showed no concern over the act or her condition, and explained that a 'voice from Above' had advised her to cleanse herself of her sins by fire.

When patients are from families in which suicides are known to occur this should increase one's concern over the possibility of such an act by a depressed patient. Responsible relatives should also be advised on the increased hazard of leaving the patient alone in the morning when he is apt to be most despondent. Of equal concern is the sudden improvement in the depressed state since such seeming elation may result from the patient's decision to solve his problems by suicide at the first favorable opportunity

This is of particular importance when the patient is released for a weekend at home after a brief period in the hospital. The

family leaves the patient alone for a few minutes and he shoots himself or he decides to walk down on the beach and fails to return. The family's explanation is always the same. He looked so much better and seemed so improved that we never thought he had this in mind."

The treatment of depression is a medical problem. A psychiatrist may supervise others in the treatment of those depressed but his clinical judgment must determine the course treatment is to follow. In the depressed, philosophical discourse is seldom effective in shortening morbidity or in preventing suicide.

Finally, the greatest concern is the despondent individual who concludes that the members of the family, particularly the children, should not be left behind in the misery from which he is escaping and decides to destroy first his family and then himself.

The predictable rate at which suicide occurs in a given population is somewhat foreboding, since those said to have such a 'vague general aptitude' appear to move rather relentlessly to their appointed year to become statistically reportable. This rather stable rate at which suicides occur led Durkheim to conclude in 1897 that this particular type of lost tranquility lent itself to consideration as an entity distinct and apart from the one committing the act and was the result of a common cause which dominates and survives the individual', this conclusion remains somewhat of a heresy today.

The rate at which suicides occur apparently is influenced by conditions affecting the total society in which the individual lives (such as war, prosperity, and depression) rather than events unique to the person. It has been further observed that those who suffer most are not those who kill themselves most. Rather it is too great comfort which turns a man against himself, life being most readily renounced at the time and among those where it is least harsh.

Men are three times as likely as women to become so disturbed as to destroy themselves, and lose their tranquility so regularly with age that half of all suicides reportedly occur in males over 45. The clinician should surely keep this hazard in mind in his management of the older male patient. He cannot restrict the activities of each mildly depressed patient he treats but he should be aware of a foreboding change in the degree of depression.

## MANIA

### *Hypomania*

This is a state of overactivity of a lesser degree than is seen during a manic episode. The patient is able partially to control and direct his increased drive and energy. Such individuals are over-talkative, prone to carry any activity to excess, and do not appear to tire as easily as others.

This may be a sustained state in which the individual is aggressive, intolerant of opposition, and untroubled by doubt. If the hypomanic is capable and directs his energy, he may accomplish a great deal. The combination of excessive aggression and excessive self-confidence makes for impatience, quick decisions, and opposition.

A 46-year-old executive who describes himself correctly as a "self-made man," leans forward in his chair, pounds the desk or snaps his fingers to emphasize his points, while he fires questions regarding his alcoholic wife in such a manner that any answer given will be to her disadvantage and will substantiate his conclusions.

He sleeps an average of four or five hours a night, runs his business with an "iron hand," smokes an average of four packages of cigarettes a day, and occasionally drinks to excess so he can "relax."

He quit school his first year in college because he wanted to be independent and "needed the money" although his family was financially quite able and much opposed to his leaving. He approached his work with the same amount of aggression he had available for any task, and at the end of the first year recalled that "he took his employer in as a partner" and bought the business.

## MANIC

The manic patient is characterized by over-talkativeness and over-activity of an unusual degree. Such patients are very distractible; one idea is no sooner begun than dropped, and a concise statement cannot be given as one irrelevant detail after another is included. The patient may interrupt the conversation to break into song, crack a few jokes, or express his irritability.

The individual may be euphoric and take great pleasure and amusement from his own remarks. The over-activity may be con-

tinued until the patient is exhausted; he may sing and shout until he is too hoarse to be heard. The over-activity is as marked in the sexual sphere as in other areas. This is evident in the female who expresses her desires without ordinary restraint or subtlety.

The extent of the manic state can only be judged by a comparison with the patient's premorbid behavior. This is well brought out by the following case:

The patient, a 38-year-old male, had always been rather reticent socially and sexually, according to his wife. They were married three weeks before intercourse occurred, and once or twice a month was his usual rate of performance.

Approximately six weeks before admission the patient's wife had noticed a change in her husband's behavior socially. Previously, he had been quite content to listen and "take a back seat"; she was amazed to hear him referred to as "the life of the party"; he became witty, talkative, and reluctant to depart when the evening was over. At about the same time the frequency with which he desired intercourse began to increase; at this point both the patient and his wife were mildly euphoric.

Two weeks before admission the patient had become somewhat arrogant with those where he was employed, and his mood varied between a joking, too-good humor and threatening irritableness if he were opposed.

He was admitted after he went to the local depot, bought a ticket to New York, deliberately waited until the train had departed, and then demanded his money back. He then bought a second ticket on the next train scheduled to depart, which happened to be going in the opposite direction, and repeated the performance. The ticket agent, somewhat weary and a little irritated with the proceedings, called in the police who were berated along with the agent except for brief pauses when the patient sang "God Bless America" at the top of his lungs.

After he arrived at the hospital, while being admitted he grabbed the phone and yelled. "Come on up, Honey, I'm stopping at the Waldorf." Each morning on rounds he referred to the staff as "educated apes" and added that so far as he was concerned they could "suppose" the hospital. When everyone looked puzzled, he explained in a condescending manner that "Suppose was the past tense of suppository." He also presented each staff man with a spoon he had bent double, as a souvenir of his visit to the institution. This particular behavior was

terminated abruptly by the cook whose irritability was a little more marked than the patient's

## TYPES OF AFFECTIVE DISORDERS

### *Involucional Psychotic Reaction*

These disorders occur at midlife and in the past were described as 'involucional melancholia' or 'midlife depression'. However, paranoid ideas may dominate the clinical picture, with the disturbances in mood being less conspicuous or absent.

Involucional psychotic reactions usually occur in patients with a personality structure of the compulsive type without a history of a previous depressive episode. Such individuals may also be described as rigid or unbending during their earlier years, tending to be prim, exact, precise, and somewhat distant in their relations with other people and severe in their attitudes toward themselves (or towards their bodies, as Moore said).

Other patients who develop involucional psychotic reactions appear more sensitive than rigid or compulsive, having what Kretschmer calls a 'tender' nervous system, which causes them to avoid the 'common' and the gross and to seek the esthetic interest. Such people are more 'hurt' than angered.

Avoiding as they do vigorous argument or activity, events which others less sensitive regard as trivial (or do not perceive) assume exaggerated importance for these people. A wrinkled coat, a spot on a tie, a crude remark may quietly ruin a day. One such patient though severely depressed, expressed regret over her inability to eat and the trouble she caused, and made no complaint over being tube fed. Another, in spite of her extreme discomfort, apologized not only for her symptoms but for being so 'lacking in character' as to have to complain.

The type of premorbid personality is diagnostically important in differentiating these patients from the cyclothymic individual who is inclined to manic-depressive disorders.

### CLINICAL DESCRIPTION

The patient is usually agitated as well as depressed. The illness begins insidiously, with an increased preoccupation with self and



decreased in external interests as the agitation becomes more difficult to conceal. The appetite fails and insomnia becomes a severe problem, the patient begins to pace the floor and wring his hands; he may be heard to mumble to himself of his worthlessness.

Somewhere sometime during his past life the patient finds something over which he may berate himself. A 52-year-old female bemoans a premarital experience at 18; a male of 54 with bowed head admits he slapped his wife when he was 26.

As the illness progresses the guilt becomes less personal and more global. He should be 'put away' because of the particular disease he has, he no longer deserves to be among humans for he has committed the unforgivable sin. In the past, syphilis was the disease of choice as a basis for being shunned by society but since it is more treatable this complaint is rarely heard.

Other patients may express somatic delusions particularly regarding the gastro-intestinal tract, or the agitation may be lacking and retardation or apathy may be more in evidence. Paranoid delusions may be the chief symptom which may so concern the patient that little affective disturbance is noted.

### *Manic Depressive Reactions*

These reactions characteristically show extreme deviations of mood with a tendency to recurrence and remission. In the past they were diagnosed manic-depressive psychosis. Secondary or accessory symptoms such as delusions, illusions or hallucinations may be added to the underlying mood disorder.

#### MANIC TYPE

This type shows a generalized functional over-activity in all spheres with overtalkativeness, increased motor activity, and a flight of ideas. This over-activity is accompanied by an elated overconfidence, aggressiveness, and irritability.

#### DEPRESSED TYPE

This group shows an anergic state with a depressed mood; a retardation of both psychic and motor activity is usual. The patient may also be anxious, restless and apprehensive.

## OTHER TYPES

In this group are placed those cases which show elements of both a manic and a depressed state, or alternating episodes.

*Psychotic Depressive Reaction*

Patients classified in this group have a depression of a psychotic degree but differ from a manic-depressive, depressed reaction as follows: first, the patient does not have a history of cyclothymic mood swings or repeated depressive episodes; or second, the presence of environmental precipitating factors is evident. Reactive depressions of psychotic proportions are classified in this group of psychotic depressive reactions.

# 13

## *SCHIZOPHRENIC REACTIONS*

History and Concepts of Schizophrenia

Theories on Etiology

Hereditv

Psychoanalytic Theory

Physiological Changes

Body Types

Prepsychotic Personality

Effects of Isolation from Group

Interpersonal Withdrawal

Symptoms

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Disorders of Association

Autism

Disorders of Affect

Secondary (or Accessory) Symptoms

Hallucinations

Delusions

Disorders of Volition (or Will)

Schizophrenic Reaction Types

Hebephrenic Type

Simple Type

Paranoid Type

Catatonic Type

Acute Undifferentiated Type

Paranoia

Other Types

Paranoid State

## *Schizophrenic Reactions*

Schizophrenic Reaction, Chronic Undifferentiated  
Type

Schizophrenic Reaction, Schizo-affective Type

Schizophrenic Reaction, Residual Type

*" The therapy of schizophrenia is one of the most rewarding for the physician who does not ascribe the results of the natural healing process of psychosis to his own intervention " —E. BLEULER*

Schizophrenic reactions are a group of psychotic reactions showing characteristic symptoms. These symptoms include a splitting or loosening of associations with a severe disturbance in reality and affective relationships. (There is a tendency to withdraw from the external environment, to demonstrate regressive behavior, and in many cases to show an emotional 'deterioration'. The term schizophrenia is synonymous with dementia praecox.)

## HISTORY AND CONCEPTS OF SCHIZOPHRENIA

In 1849 Conolly in England described young persons who suffered a state resembling melancholia without apparent cause, following which they became indolent and mechanical in their behavior. He noted that those so affected showed a deadening of the passions, emotion and intellect and became 'totally apathetic'.

Morel (French) in 1857 was the first to use the term dementia praecox, he stressed the early age of onset, rapid course, and eventual dementia. In 1860 he described a boy of 14 who rapidly lost his previous excellence and cheerfulness and became instead sober, taciturn, and showed a 'kind of inactivity bordering on stupidity. The boy demonstrated an increasing forgetfulness of what he had previously learned, his intellectual faculties, formerly so brilliant, came to an alarming standstill."

Kahlbaum (German) in 1863 described paraphrenia (age bound disorder) and in 1874 catatonia. Hecker (German) in 1871 deline-

ated hebephrenia from the paraphrenias previously described by Kahlbaum Falret (French) in 1878 described, as an entity, those disorders showing character change and delusion, hallucinations and megalomania

In 1896, Kraepelin in Germany described dementia praecox as a single disease entity. The three principal subtypes of dementia praecox first delineated by Kraepelin were hebephrenic, catatonic, and paranoid, he later added a simple type. Schizophrenic reaction types followed in the present classification are in keeping with these four major subdivisions.

In the eighth edition of his *"Textbook of Psychiatry,"* Kraepelin grouped these disorders under the heading of "endogenous dementias" and characterized them as follows: they arise from internal causes and are not occasioned from without, and the great majority lead to mental enfeeblement.

He defined dementia praecox as a series of states characterized by a "peculiar destruction of the internal connections" of the personality, this injury being most marked in the areas of emotion and volition. The name dementia praecox, previously used by Morel and Pick, was considered adequate. He added that until more understanding occurred, the preferable term for these disorders would be the one which said nothing, otherwise, the name would be misleading as to the nature of the illness.

Kraepelin observed that similar states of dementia developed in patients who showed varied symptoms at the onset of their illness, and that a relationship between these illnesses and youth appears to exist. He held the cause to be either a degenerative process involving the central nervous system or a metabolic disorder producing a state of auto-intoxication.

Kraepelin stressed the importance of such findings as a failure to have any "strong feeling of the impressions of life," automatic obedience, negativism, and a lack of volition (or will) occurring in those with an unimpaired ability to understand and remember," as being diagnostic of dementia praecox. Such terms as "emotional enfeeblement," "mental weakness," and "feeble-mindedness," particularly the progression of the illness to "a state of dull indifference," are repeatedly used to categorize this condition.

Kraepelin's clinical descriptions of these patients have yet to be improved upon, as shown by the following excerpts from his description of a paranoid patient

'The merchant, aged 25 whom you see before you today, has made himself conspicuous by putting leaves and ferns into his buttonhole. He takes a seat with a certain amount of ceremony, and gives positive, concise, and generally relevant answers to our questions. Although he knows where he is, he mistakes the people about him calls us by wrong names and takes us for merchants. While he is more or less indifferent at first, taking very little interest in us and looking around with a concerted expression he gradually becomes rather excited grows rude irritable and threatening, and breaks out into an incoherent flood of words, in which there is a quite senseless play on syllables. He denies that he has hallucinations. He declines to obey orders but after some persuasion he finally stretches out his hand slyly to shake hands. The patient is divertible, he often breaks off in his talk, and he intersperses it with curious snorting noises. His mood is changeable, but on the whole very much exalted. Often, more especially when he makes his jesting play on words the patient bursts into a tittering laugh. His behavior shows no marked excitement. His deportment is pompous and affected.

'The diagnosis will have to rest principally on the peculiar aberrations in the patients actions—the mannerisms, the play on words, the signs of negativism, and also on his emotional indifference, while he is yet quite collected. The patient does not consider himself ill but stays here without making any resistance, does not worry at all, forms no plans for the future, and expresses no desires. We know this picture well already as a form in which dementia praecox appears.'

Kraepelin noted that the acute forms of dementia praecox frequently began with a state of 'apprehensive bewilderment'. He stressed the poor prognosis and the 'profound change in the whole character' which usually followed a psychotic episode. It was stated that the possibility of a complete and lasting recovery could not be excluded but that a tendency to relapse showed the illness caused a degree of infirmity. He felt that in those who recovered, the following traces of the previous illness could still be found: a loss of emotional feeling, an absence of understanding of the past illness, a lack of freedom in action and behavior, affectation, obstinacy, and a reserved and inaccessible character.

Meyer (American) in 1906 described dementia praecox as a result of disorganization of functions and deterioration of habits. The study of the mentally ill then became a study of faulty adaptations to life or of an understandable attempt at adjustment.

Meyer discarded the previous concept of a separateness of mind and body and sought to understand schizophrenia (parergasia) in terms of the patient's response to previously experienced events. Such a psychobiological approach gave meaning to the patient's seemingly bizarre activity and afforded a 'longitudinal' view which in turn clarified the behavior witnessed at any given moment.

Meyer stated these groups showed "substitutive reactions" with a discrepancy between thought and reaction, along with odd defects of affect and interest. He further stated that by using available psychobiological material, the main facts of most cases could be formulated 'in terms of a natural chain of cause and effect.' This approach, he held, was more rewarding than the dogmatic assumption of a 'hypothetical unitary toxic principle'.

He stated a loss of balance occurred based on habit deteriorations, and the subsequent reactions were biologically unfavorable to the restitution of a normal attitude. Essentially, there is a failure of compensation of efforts at adjustment, usually with a deficit and peculiar attempts at reconstruction. In some a strong constitutional bias exists which requires little extraneous cause to produce the illness, whereas others appear superficially normal and a preponderance of external etiological factors are evident.

The general features of dementia praecox include the oddity and incongruity of the whole picture in spite of the patient's relative clarity, a striking narrowing of the resources for adequate reaction, and a morbid personality reconstruction. Dementia praecox is usually the outcome of 'conflicts of complexes of experience' with an incapacity for harmless constructive adjustment.

Schizophrenia was then not a recently acquired, discrete and independently arising state, but the overt result of an extended period of disorganization of function or 'habit deterioration'.

In 1911 Bleuler, a Swiss psychiatrist, after years of observation of patients diagnosed as dementia praecox, introduced a different concept and name for this disorder.



Bleuler first rejected the idea of deterioration as routinely occurring, he, and others, had noted patients (particularly catatonics) who symptomatically fitted Kraepelin's description but were excluded diagnostically because they did not progress to a deteriorated state. He next pointed out that neither deterioration nor onset regularly occurred at puberty and consequently were not necessarily 'precociously' beginning. In 1911 several other terms already had been coined in attempts to overcome these discrepancies such as *dementia simplex*, *dementia primitiva*, adolescent insanity, and others none of which he considered accurate or satisfactory.

Bleuler stated that in every case there was a more or less clear cut splitting of the psychic functions. This splitting up of the "psychic complexes" with a resultant loss of unity and integration of the personality, and a subsequent domination by first one split off complex and then another was held to be basic to the illness. The term '*schizophrenia*' was therefore chosen in preference to *dementia praecox*.

Schizophrenia was defined as a group of psychoses, at times chronic and at others marked by intermittent attacks which could cease at a given stage or in which improvement could occur, but in which a full restitution to the premorbid state was not seen. Characteristically, a specific type of alteration of thinking feeling and relation to the external world unique to this illness was described.

In addition to clarifying the clinical course of this most difficult illness, Bleuler, and his assistant Jung applied Freud's analytical concepts to these patients and gave increased meaning and understanding to their symptoms and their efforts to communicate.

Bleuler felt that etiologically an anatomical or chemical disturbance of the brain had to be assumed. This disturbance presumably was chronic but might become acute or quiescent. This disturbance produced the primary symptoms the disorders of association, and in severe exacerbations certain confusional and stuporous states.

In 1931 Manfred Bleuler reviewed his father's work and named as primary symptoms disorders of association and affectivity and

as secondary symptoms autism, delusions, illusions of memory, hallucinations, and most of the catatonic signs.

## THEORIES ON ETIOLOGY

### *Heredity*

Studies of the incidence of schizophrenia in the general population reveal a frequency of from 0.4 to 0.85 per cent whereas rates of from 9.1 to 16.4 per cent have been reported of children with one schizophrenic parent. An incidence of 14 per cent in full siblings and approximately 86 per cent in monozygotic twins has been found by Kallman. Slater, in a similar study, reported a concordance rate of 76 per cent in a smaller group of identical twins.

Although there is a rather general acceptance of a higher incidence of schizophrenia among the relatives of such patients than in the general population, the mode of inheritance is not yet agreed upon.

Malzberg found an admission rate of 2.1 to 1.0 for urban as compared to rural areas. Since the schizophrenic characteristically lacks insight and is more apt to be brought for treatment than to seek it, the patient in the more isolated rural areas with fewer contacts with others would have an understandably smaller likelihood of being admitted. According to marital status, he also found a lower incidence among the married as compared to the single, with those divorced having about the same vulnerability as the unwed. Apparently those able to marry, and continue the relationship for better or worse, have a tolerance for stress the unmarried lack.

### *Psychoanalytic Theory*

Freud observed that schizophrenic patients did not conform to the theory of a conflict between the ego instincts and the sexual instincts as patients with transference neuroses did. He then concluded that the schizophrenic failed to gain satisfaction externally, and consequently, the object libido was withdrawn, repressed, and retreated into the ego. The ego then takes itself as an object; as the external world is repudiated or denied, and the patient withdraws and becomes apathetic and disinterested. The basic conflict is between ego-libido and object-libido.

In addition to the normally occurring primary narcissism (ego-libido or self love) the schizophrenic shows a secondary narcissism. This develops as the libido is withdrawn from people and things and the patient takes his own ego (in phantasy) as an object.

### *Physiological Changes*

The search for an organic cause for schizophrenia has involved postulated toxins, altered metabolic states, and structural changes. Various areas in the central nervous system as well as endocrines, glands, and organs have, on one occasion or another, been suspect. In 1910 Meyer remarked that "the best investigators have so far least to say" regarding specific or decisive metabolic or toxic states in schizophrenia. Unfortunately this remark is still true today. There seems little cause for doubt that the eventual understanding and rational treatment of this group of disorders will evolve from some such investigation.

It would seem that a greater individual variability may occur in physiological measurements in the schizophrenic than in the normal, but that no consistently occurring variation, peculiar to these patients, is as yet demonstrable. This tendency to individual variation is exaggerated by the schizophrenic patient's frequently malnourished or dehydrated state.

### *Body Types*

Attempts to correlate physique and temperament, and body habitus with a particular type of mental or somatic illness are not new. Hippocrates described a phthisic and apoplectic habitus as two extremes of body types. Those with a phthisic habitus were described as being long and thin and vulnerable to tuberculosis, whereas the apoplectic was thick, solid, short of extremity, and prone to vascular disorders.

Rostan, in France, in 1828, described three types which later classifications tend to follow, namely 'type digestif,' 'type musculaire,' and "type cerebral." Viola in 1909 again classified individuals into three groups, which he called microsplanchnic, macrosplanchnic, and normosplanchnic.

Kretschmer, in Germany in 1921, published his monograph on

"*Physique and Character*" in which he related body type to temperament. These relations were based on observations recorded by trod ding 'the bitter, wearisome road of systematic visual description and inventory of the whole outer body from head to foot." When ever feasible, these observations were directly measured by tape and with calipers in the most minute detail. No casual impressions were allowed, the patient was examined "standing naked before us in bright daylight."

The asthenic habitus was described in those having an average height with a "deficiency in thickness", they are lean and narrowly built, appearing taller than they are, with narrow shoulders, thin muscles, delicate hands, and a long narrow chest "on which we can count the ribs." Those with an asthenic habitus show a "clear biological affinity" for the psychic disposition of the schizophrenic. A similar but less frequent affinity is found in others with an athletic or dysplastic habitus.

In 1940 Sheldon described his somatotypes as follows,

1 *Endomorphs* have a predominance of those structures evolved from the endoderm. The digestive viscera are relatively massive. These people have round, smooth, soft bodies in which the thoracic and abdominal volume are excessive as compared with their extremities. Characteristically they are comfortable, enjoy their food, are at ease with others, and express their feelings easily.

2 *Mesomorphs* are those with a predominance of structures whose origin is from the mesoderm, that is, bones, muscle, connective tissues, heart, and blood vessels. They have more angular bodies with lines broken by muscle mass or prominent bones, the thorax predominates over the abdomen. This type is active, energetic, assertive, noisy, and aggressive.

3 *Ectomorphs* are those showing the greatest relative development of structures of ectodermal origin, that is, skin, hair, nails, sense organs, and brain. The skin surface is relatively greater than in other types (also, they are in relatively greater contact with the external environment). They are longer and more delicately formed, and their extremities are long as compared to the abdomen and thorax. Such people express themselves with difficulty, are sensi

tive to noise and other distractions. They frequently prefer undisturbed solitude to the company of others.

Sheldon found that schizophrenics show a conspicuous amount of dysplasia. He also found evidence similar to Kretschmer's that a schizophrenic has a tendency to be an ectomorph (particularly the hebephrenic and catatonic types).

### *Prepsychotic Personality*

Perhaps the most characteristic feature of the schizophrenic's behavior during the prepsychotic years is an inability to socialize. To socialize implies more than the individual's physical presence at a function, since he may have had an aggressive parent who maintained a total push program during his years at home which assured his being present at the usual social activities.

But what happened after he arrived? In the beginning he (or she) may have appeared shy, this shyness in time giving way to irritability and peculiarity. Some may early assume rigid, unaltering and stilted types of behavior in an effort to endure more comfortably their encounters with others. The schizophrenic apparently is unable to feel himself a part of any group or, as Kretschmer's patient said, "There is a pane of glass between me and all mankind."

This inability to socialize may at first appear as an undue reticence or shyness, which with time becomes more odd, strange and peculiar. Whitehorn and Betz attribute this social distance in part to a fearful and hateful lack of faith in himself and others.

The isolation from the peer group is aggravated by an inability to communicate. The potential patient's experiences with others disturb rather than gratify, and he tends to withdraw and avoid the discomfort other people bring. But satisfaction is equally lacking in his isolation, and he becomes increasingly critical of self, this criticism frequently amounting to self-hate. The defects the patient finds within himself are presumably equally evident to others, which he may utilize to explain their derogatory remarks and withering glances.

If the schizophrenic's prepsychotic behavior is considered as being progressively dominated from within as he becomes more ill,

then his increasingly inappropriate response to his external environment becomes more understandable. The bizarre behavior, the lack of interest, the unpredictable changes in mood may be wholly unrelated to the patient's external circumstances, but quite in keeping with his inner preoccupation and perplexity.

Since the cocktail party shows little evidence of disappearing from the social scene, it would seem most people have some social shyness or self-consciousness around strangers. However, the shy individual becomes acquainted and becomes at ease; but with the schizophrenic, strangers remain strange or, what is worse, they continue to be unpredictable—sometimes friendly, at other times threatening.

#### EFFECTS OF ISOLATION FROM GROUP

The isolation, the lack of a feeling of pleasure and security in the company of his peers presents tremendous obstacles to the growing individual, which may suddenly become overwhelming at puberty. Perhaps the greatest obstacle is the patient's having to rely primarily on introspection for understanding of self; since he can only communicate with any degree of comfort on an impersonal basis, his disturbing personal problems must be resolved within. The answers he arrives at are not checked or balanced against the opinions of his peer group; consequently, he creates a structure and a pattern of behavior on his own presumptions which others cannot understand and, being unable to communicate, he cannot clarify.

Slowly and insidiously the individual tends to withdraw affectively to avoid the displeasure that other people bring. He is constantly aware of self in a critical way. What he says fails to convey what he means; so he may repeat the idea to himself before he expresses it, and his speech may become affected, stilted, and utterly lacking in spontaneity.

Later he belittles himself, derides his social failures as though another within him were responsible—"you should have done better," "you should have talked more," until this "you" may be split off and denied, being intolerable as a part of self.

A similar type of self-criticism may be evident in the patient's auditory hallucinations, in which the derisive "voice" he hears makes derogatory remarks about him. Other patients, when ques-

tioned answer as though a third person were being discussed. When asked "How have you been?" a chronic patient replies "Oh she's been fine." She was then asked "Did you take your medicine?" and answered "Yes," she took the pills.

#### INTERPERSONAL WITHDRAWAL

The unending failure in attempts to express affection, the lack of satisfaction with others, and the increasing self-hate these engender gradually overcome the individual from within. The external world is perplexing, disappointing, and the inner turmoil is increasing; the individual withdraws as he is more and more occupied with his unending attempt to find answers to his bewilderment. He no longer has time for the external; all his waking hours are spent ambivalently pondering.

His thought ceases to be modified by what transpires about him; he cannot accept more perplexity while he is still battling the unsolved problems that he earlier experienced. He is left farther and farther behind by his group, and his peers become ridiculing strangers; his thinking is pathologically narrowed and stereotyped by the endlessly repeated introspection. His autism and preoccupation within leave him no means or desire for contact with the external environment which he has already tried and found wanting. As his behavior and conversation are increasingly motivated from within, they correspondingly lose meaning to the observer and seem more strange and bizarre.

It must be clarified that the schizophrenic becomes through failure or inability to socialize, as Hoch described, a shut-in personality. He may be withdrawn, wanting friends but unable to make them; emotionally apparently unresponsive and varying in his behavior from apathy to irritability. Given to odd expressions or concerns, confusing the concrete and the abstract, and foregoing spontaneity for stylized response, an emotionless smile, or a malignant apathy, he may be avoided by others which serves to increase his isolation.

Finally, he may cease to show interest in his appearance or his responsibilities, or in food, or in his own continence. The attempts by others to make him socialize, to move, to talk, and to act as they

do, may be extremely irritating since they interrupt the demanding and consuming repetition of his autistic thoughts. He may then be hospitalized and show the same apparent lack of interest in the change that was expressed in the home from which he was removed.

## SYMPTOMS

Eugen Bleuler held that disorders of association were primary and pathognomonic of schizophrenia. In 1931, Manfred Bleuler reviewed his father's work and included both disorders in association and affectivity as primary. In an effort to adjust to these primary disorders, the secondary symptoms evolved, which include hallucinations, delusions, autism, stereotypies, and most of the catatonic signs.

### *Primary Symptoms*

#### DISORDERS OF ASSOCIATION

Conversation is dominated by a purpose, namely to communicate and clarify an idea which exists as a goal with the speaker; without this purpose or goal, or the speaker's intent to clarify, the words cease to be associated in a meaningful way. This seemingly occurs in the schizophrenic, whose attention is not held by a goal idea: "... The habitual well-worn pathways of association have lost their cohesiveness."

In ordinary conversation, words are chosen for their meaning, both for the speaker and the listener; words which merely sound alike and which are unrelated to the topic are rejected. The speaker selects the appropriate words to clarify his meaning; this selection the schizophrenic does not bother to make.

Schizophrenic speech may wander unhindered from one chance association to another without particular purpose, or the patient may repeat the same word purposelessly or join words which sound alike without regard for their meaning. There is an "absence of directing principle."

These disorders of association are manifest as follows.

There is a tendency for speech and behavior (and the thought behind it) to become stereotyped. The patient may simply repeat,



"I don't know, I don't know" regardless of the question asked. There is a marked lack of spontaneity or originality. There is a lack of ideas, patients say it is difficult to think or that their thoughts have been stolen. "Blocking" is frequently seen, the patient ceases talking for a few moments or several minutes and may resume on some other topic.

Associations may be made on the basis of the similarity of the sounds of the words or a connection unrelated to the present use, such factors as time, place, and function may be ignored. Bleuler illustrates this with the question, 'Who was Brutus?' and the schizophrenic's partially correct answer, 'He was an Italian,' thereby ignoring a sizable interval of time. Another example, a patient from Lincoln, Nebraska is asked the name of her home town, she replies, Lincoln, or was it Eisenhower? Another chronic patient is asked what she would do if discharged and replies, 'Raise my children to be morally straight, physically strong, and symmetrical.'

The associations may be related to a general idea without regard for clarity and not restricted by any particular purpose. The patient may eliminate the clarifying meaning and background of an idea or concept and condense whole sentences or paragraphs into a single word. For instance, a patient is asked, 'How do you feel today?' and replies, "I'm a crumple," by which she means she is overwhelmed by the phantastic demands made on her and the plot against her.

Words may be given a personal meaning by the patient, the use of the word, being determined internally, is not related to the commonly accepted meaning and conveys nothing to the listener. This breakdown in associations gives schizophrenic conversation its uniquely bizarre character, and the patient's behavior an equally odd appearance. This oddity and queerness of speech and behavior is more comprehensible if it is seen as being dominated from within the patient, being little if at all modified by external stimuli. This also gives the interviewer pause when he first attempts to obtain a routine history from a schizophrenic patient.

Ambivalence (a term coined by Bleuler) refers to the schizophrenic's difficulty in bringing the different aspects of any problem

together, due to his weakened associative linkings. Granted that everything has two sides, for the healthy as well as the ill, the schizophrenic is perplexed both by the double evaluation of the experience and his own double attitude toward the experience. This ambivalence may be intellectual or affective. To feel equally about any act or experience is immobilizing and makes for perplexity rather than resolution.

*Autism* The splitting of psychic functions leads the schizophrenic to exclude associations which conflict with emotionally charged complexes. As reality progressively becomes less satisfying, a substitute is sought in phantasy and where contradictions exist reality is denied due to the dominance of the patient's affective needs. Finally, the autistic thought, the phantasy, assumes a complete reality value. This loss of concern with reality is in those areas which conflict with his affective complexes.

#### DISORDERS OF AFFECT

Some patients show an apparent lack or blunting of affect, in others there may be a prevailing mood of euphoria or depression unrelated to external circumstances. A 26 year-old male during a remission following a psychotic episode which terminated in a catatonic stupor, recalled his mirthless laughter at the onset of his illness which he remembered puzzled him even as it occurred. It was more irritating than enigmatic to his somewhat intolerant family, and the more his father demanded he stop, the louder he laughed. Bleuler described an unusual or overwhelming sensitivity initially in many patients, which is followed by an emotionally dull or unresponsive state.

The extent to which a schizophrenic may ignore external stimulation is illustrated by the lack of response to pain which occurs in some patients, who may physically mutilate themselves without evidence of discomfort. As the patient who was to be transferred to another job in a different part of the hospital, and showed neither enthusiasm nor evidence of displeasure over the impending change, but shortly thereafter calmly nailed his feet to the floor so he would not be moved.

Frequently, the affect is inappropriate to the expressed thought,

such as a patient laughingly describing the tortures he is enduring. This striking incongruity between idea and affect is a frequent symptom during the development of this illness. Jung pointed out that this incongruity could easily result from the peculiar seclusiveness of the schizophrenic and the fact we see very little into them.

Schizophrenics may show hostility which is pathological in its intensity and in the lack of an external cause to provoke it. Where appropriate the affect seems to lag behind expressed ideas and the patient is unable to adapt rapidly and normally to changing currents of thought. The apparent deterioration of affect is not irreversible even in the chronically ill.

Neisser (quoted by Jung) described a fixation of affects in which those emotions normally acting to regulate the relationship of the patient to his environment were alienated from their natural destiny. This alienation and fixation of affective response led to a destruction of the ability to feel joy or compassion with the patient's becoming emotionally isolated.

People, events and objects seem in some patients to have equal emotional meaning since they are described with the same degree of feeling and in the same tone of voice. A 20-year old college girl seen as an outpatient described for 45 minutes without apparent affect inflection of her voice, change of expression or evident concern all that had occurred to her during the week. The activities and events described included an uncle's death, the evening meal following the funeral, her opinion of her school work, and her unconcerned observation of a homosexual affair between her roommate and another girl.

### *Secondary (or Accessory) Symptoms*

#### HALLUCINATIONS

An hallucination is a false sensory perception arising without an external stimulus.

Auditory hallucinations of a persecutory nature are the most frequently occurring although hallucinations of taste and smell are also complained of. The accusatory voices may be argued with or accepted, they may be whispered or they may be voices that do not

speaking with words, a patient may not reply because the "voice" advises against it. The 'voices' may be denied although the patient blocks and assumes an attentive attitude as though listening.

The auditory hallucinations may be recognized as arising within the patient, whereas on other occasions a patient may stop his ears with paper to keep them out. Some of the voices may be "good" and others "bad," depending on their source and content.

The intensity, distinctness, and reality value of hallucinations may be as great or greater than perceptions. The 'voices,' like the patient's thinking, tend to become stereotyped. Sexual sensations, either overt or symbolically represented, may be displaced from the genital region to other areas of the body. Visual hallucinations are rare and are less real than auditory hallucinations.

#### DELUSIONS

A delusion can be defined as a false belief out of keeping with an individual's level of knowledge and not shared by his cultural group. The belief is held in spite of logical argument or proof to the contrary.

These are most frequently of a persecutory, derisive nature in which the patient is ridiculed, frustrated, or belittled. In those with delusions of grandeur (megalomania) the individual is convinced of his great importance and ignores the contradictions so obviously in evidence. For instance, a patient casually implies his omnipotence by saying he is the Lord, and then asks why he cannot be transferred to another ward.

In many cases there is little connection between the expressed delusions and behavior. The patient may attribute his delusions to another and say they are forced upon him but he still believes them. The delusions remain alien to the ego or self, and the contradictory elements of the delusions are not brought into logical association with reality to be tested. A patient blithely explains after 17 years in a hospital that she never was sick nor needed hospitalization but is there because she is a victim. She was then asked if she had been happy these 17 years and replied, "Oh, sure. Some are intended to be victims."

In the schizophrenic the delusions may change, be altered or a

peculiar idea may be only briefly present before being replaced with another. A conviction of having been poisoned is a frequently held delusion, this poisoning may occur through food or by inhalation, and may manifest itself in several ways. Delusions tend to spread from an individual to include groups, first a fellow worker is "spying on" the patient soon all the other employees are similarly engaged, and before long strangers in the street have entered the plot.

Areas which are not disturbed include such functions as memory, consciousness, motility, and perception. These are not directly affected but only appear to be disturbed as a result of the apathy, indifference, or failure of the patient to respond. It may be presumed that these functions will be affected as they are in conflict with the patient's affective complexes.

#### DISORDERS OF VOLITION (OR WILL)

As previously described, schizophrenia is a reaction of withdrawal and avoidance of the environment, an attempt to escape irritation and remain at ease by isolation of self from others. As the patient's thought becomes more autistic and his concern with reality fades, his enjoyment of activity declines. Work is no longer pleasurable, they lack the urge to action either from within or with the encouragement of others. Obligations, interest in self, interest in others, anticipation—all fail to provoke concern. Time stops, boredom ceases to bother. In essence, these changes would appear to follow a failure to gain pleasure from the environment.

Patients complain they do not control themselves but that they are controlled or influenced and may be even puzzled by what is occurring to them. A 24 year old male, following his recovery from a catatonic episode, described his days spent standing in the hall repetitiously turning about in a stereotyped manner, as follows: "I don't know why I turned, I felt like I had to turn. It was like something was on the back of my head making me turn."

His failures may become inevitable in the revelations provided by his delusions, he could not succeed since it was intended by someone else that he should become a 'victim'. He was not inadequate, he was held back by a 'master plan', he sees indication and

"proof" that he is actually being used and controlled by the environment that he has never been able to comprehend.

Finally, in considering the schizophrenic in his environment, a hierarchy of needs must be postulated; in the schizophrenic, the demands for the satisfaction of the basic needs from the external world, and the behavior which leads to their gratification, are replaced by the overwhelming demands from within. These inner needs are neither satisfied nor greatly affected by the external environment, which, as a consequence, is for the most part ignored:

### SCHIZOPHRENIC REACTION TYPES

The predominant symptoms, both past and present, are the determining factor in classification. The longitudinal view including the prepsychotic behaviors and previous episodes must be considered in the diagnosis.

#### *Hebephrenic Type*

This group was first described by Kahlbaum and Hecker and their patients were characterized as follows. They became ill early in life and showed marked evidence of immaturity and callousness and were given to simple pranks, clowning, and affectation. This beginning was soon followed by dementia. Kraepelin, on the other hand, stressed "hypochondrical deterioration" as being characteristic and said such patients were dominated by feelings of mental and physical incapacity and pathological sensations.

Bleuler states: "There are no specific symptoms for this group" and those symptoms said to characterize hebephrenia may appear equally in other types. He did not agree that these patients should be grouped with the simple type. Mayer-Gross prefers to place all schizophrenics in whom thought disorder is the leading symptom in the hebephrenic group. Presently, the shallow and inappropriate affect with a resultant silliness of behavior and the prominence of secondary symptoms are stressed.

*Schizophrenic reactions, hebephrenic type*, are characterized by a shallow, inappropriate affect, with silly behavior and mannerisms, with delusions and hallucinations, the illness beginning usually in adolescence, either insidiously or acutely.

### *Simple Type*

These patients seem to undergo quietly a devastation of their affectivity and intellectual interest. Kraepelin described this as an imperceptible impoverishment of their whole psychic life. They seem lacking in will, direction and activity without concern over the loss and appear possessed by a malignant apathy which leaves them devoid of interest even in their own autism.

Bleuler states these patients do not show the secondary or accessory symptoms seen in other types of schizophrenia. The destructive effects of such patients on the family may be extreme when they are querulous, fault-finding and demanding. Bleuler includes in this type the schizophrenic litigants who do not have clear-cut paranoid delusions.

Relatively few simple schizophrenics are committed to mental institutions; the majority compose the ranks of the drifters and vagrants who work temporarily as necessity demands and wander on without any particular purpose. The females of the group may become prostitutes of an unresponsive sort. The underlying schizophrenia may be concealed by a diagnosis of chronic alcoholism. Those patients more endowed may appear as ineffectual intellectuals, expert in some vagueness or other while being maintained by a parent or relative.

The severity of the illness may not be casually evident in the simple schizophrenic as he sits sullenly on the ward with his hands thrust in his pockets, staring at the floor. Lacking the bizarre immobility or the destructive overactivity of the catatonic, the demanding delusions of the paranoid or the incoherent silliness of the hebephrenic, such patients may give a deceptive appearance of integration. When spoken to, he may give an irritated or disinterested reply to questions or merely turn away from the questioner.

The lack of interest and effort causes the individual to drift lower socially, to work only as occasion demands, to be involved in petty crime and usually to remain outside a mental hospital. The course is insidiously downward over the years, seemingly with deterioration as opposed to the schizoid personality.

*Schizophrenic reactions, simple type* are characterized by a

marked apathy with a loss of interest and activity; the secondary symptoms, delusions and hallucinations, are either absent or lack prominence.

When the patient was 14 years old, he left home and drifted rather aimlessly about the country for several years. At the time of admission he had a long series of arrests for vagrancy and petty larceny for which he was jailed for short periods.

He is never combative, sits alone, and shows minimal interest in his surroundings. He socializes neither with the ward personnel nor with other patients. He works casually in the hospital dairy. He gave the following answers when interviewed.

Q: Why are you here?

Pt: I don't know, I guess so, I don't know.

Q: What caused you to get sick?

Pt: I don't know.

Q: What would you like to do?

Pt: I don't know, eat is about the only thing.

Q: Do people make remarks about you?

Pt: I don't know, I think maybe they do.

Q: What do you think about all day?

Pt: (looking at the dairy through the window) "Must be that barn over there if I think of anything."

Q: Are you afraid?

Pt: No, I don't think so.

Q: Are you happy?

Pt: A little bit, maybe.

He has been existing on this ward for 24 years.

### *Paranoid Type*

This type of reaction is characterized by the predominance of delusions. Kraepelin described this group as "Dementia Paranoides" and differentiated such patients from his "Paranoia, or Progressive Systematized Insanity."

He stressed the predominance of ideas of persecution but stated: "The paranoid schizophrenic's delusions are quite without sense from first to last and are not worked out in the mind." The delusions may be transformed but not extended, no system is evolved, and they remain fantastic fancies "only loosely coherent." In addi-



tion, the delusions in the schizophrenic paranoid were related more to hallucinations than to the misinterpretation of actual occurrences. Finally, the patients showed other evidence of a schizophrenic illness, such as a disturbance of volition and emotional enfeeblement."

Bleuler speaks of a "Paranoid Group", he described the illness as frequently developing as a change of feeling in which everyday occurrences are experienced differently, these changes may at first be questioned by the patient but gradually attain 'full credibility and certainty'."

In many patients, impersonal happenings assume a personal meaning, others thwart and play tricks on them they are ridiculed by strangers who look at them, smile at each other, and make remarks (ideas of reference). After awhile, the patient hears these derogatory remarks even though his tormenters deny them. Cars drive by his home to annoy and check on him. His neighbors gossip and spread rumors about him, he can no longer risk leaving his home, the windows are bolted and nailed down, the shades are kept drawn, he sees veiled references to him in the newspapers and on television. Eventually, he creates a disturbance at work or in the neighborhood which leads to his being hospitalized.

In other instances, the delusions may develop very suddenly, and all the previous peculiar happenings are unalterably understandable as persecutions. The patient frequently has a revelation of a religious nature following which he appreciates his true greatness and destiny. The paranoid type of schizophrenia is characterized more by sudden outbursts followed by a quiescent interval than a steady progression of the illness.

The delusions may be ideas of persecution or of grandeur. Litigious schizophrenics with delusions belong in this group. Typically, a girl employed by a physician claimed he made sexual advances to her and, when she was discharged, sought redress in the courts. When her charges were not upheld, she immediately lodged a complaint against the judge who had not ruled in her favor.

The mental mechanism most utilized by the paranoid patient is that of 'projection'. Freud states that in projection an internal perception is suppressed, distorted and perceived as arising externally.

In delusions of persecution this distortion results in a change in affect from love to hate

The psychopathology in this group is described as follows "the core of the conflict in cases of paranoia among males is a homosexual wish phantasy of 'loving a man' " This intolerable wish phantasy is distorted from love to hate, which in the symptom formation in paranoia denies the affect and replaces it by an external perception, this becomes he hates me, which justifies my hating him, with the persecutor being the one previously loved

Occasionally an acutely paranoid patient is seen with whom it is easy to communicate for a few days, however if there is an affective response on the patient's part, this is shortly replaced by hostility of an equal degree, with the physician being included with the other tormentors. Seemingly, such patients are unable to tolerate an awareness of affect or emotion in themselves except in the form of hostility

Mayer Gross takes a different view of these patients and does not separate paranoia as a distinct group from a paranoid type of schizophrenic reaction. Neither does he subscribe to Freud's theory of latent homosexuality as being causative. He points out Hagen's work stressing the existence of delusions as an attempt on the patient's part to maintain some degree of stability in his awareness, and Wernicke's description of 'delusion of explanation' evolved by the patient to comprehend the strangeness he perceives. The patient draws upon his environment for his explanations. He can only project the distorted inner affect to the external perceptions he encounters

Numerous authors have pointed out the tendency for the paranoid type of reaction to arise later in life than in the other subgroups. Kallman noted an onset at an average of 35 years in paranoia as compared to 23 in the other groups. Mayer Gross stated that a typical paranoid reaction could only be observed in an otherwise intact personality, if the illness has an early onset, the paranoia is masked by the dominating primary symptoms of the schizophrenia (with the accompanying disturbances of association, affect and volition)

In the paranoid type delusions are prominent and are most fre

quently of a persecutory nature. Ideas of reference, delusions of grandeur and hallucinations, with a persisting attitude of hostility and aggression, are characteristic.

A 45 year-old male was interviewed in a general hospital where he had been admitted for a medical work up after persistent vague somatic complaints. The patient gave a coherent history but was at times evasive. Although he had not been previously seen, he would occasionally answer a question with, 'As if you didn't already know,' and a sly supercilious look as though the examiner was already aware of the answer.

The following Sunday the interviewer was called at his home by the patient, which produced the following conversation on the phone.

- Pt. "What are you going to do with that recording?"  
 Interviewer "What recording?"  
 Pt. "The one you made of my history."  
 Interviewer "There was no recording made."  
 Pt. "I knew you'd say that."  
 Interviewer "What gave you the impression a recording was being made?"  
 Pt. "I saw all those microphones in your coat pockets."

### *Catatonic Type*

Hecker and Kahlbaum regarded catatonia as a specific disease entity, having a unique development and cause, Kraepelin noting the frequency of terminal deterioration included it as a subgroup of dementia praecox.

Kraepelin, in describing catatonia, stressed the inaccessibility of such patients, their frequently confused speech and the tendency to impulsive acts and catalepsy. He also pointed out that the development of stereotypies of speech and action were especially common in this subtype, describing one such patient, he remarked 'She rides single phrases to death in uninterrupted repetition.' The presence of mannerisms, grimacings, aimless restlessness, and 'silly activity without deep emotion' were seen as typical of this illness.

Bleuler and Kraepelin were in accord as to the frequency of an acute onset (Kraepelin found an acute beginning in 41 per cent), and that half or more of the patients showed obvious improvement after the first episode but felt there was a strong likelihood of recurrence. Bleuler states there is healing with defect or scarring.

and that following an episode complete restitution to the premorbid state did not occur Kraepelin noted that during remission the scarring was evident in a loss of emotional feeling, a lack of understanding of the previous illness, and a want of freedom of action and behavior

Others have stressed the stuporous states (whether mild or severe) as being most characteristic of this illness. Such behavioral changes as blocking or immobility, negativism, posturing, a sustained pouting expression of the lips, and hyperkinesia are most often described in this type of patient. There may be alternating states which begin with a falling off of interest, apathy, dullness, and inability to concentrate, followed by mutism, diminution of activity, and finally, stupor. This may end suddenly with a phase of marked over activity of a purposelessly destructive, assaultive, or suicidal type. After such a furor of activity there may be an improved state in which the patient offers no explanation nor has any particular interest in his recent behavior.

*Schizophrenic reactions, catatonic type*, are characterized by disturbances in motor activity varying from a sustained stuporous state to gross unpredictable overactivity.

Grimacing stereotypes of behavior and speech, negativism, or automatic behavior are also frequent in this group. Approximately half those patients with a catatonic type of illness have an acute onset and, in the majority, a remission without a complete restoration to the premorbid state may be expected.

A 19 year-old girl was admitted after a month's period of increasingly peculiar and confused behavior. When first seen, she was much preoccupied and in poor contact with reality. Following admission, she was mute, unresponsive, paid no heed to her surroundings, and was frequently incontinent.

After a course of 10 electric shock treatments the patient appeared much improved, took part in some ward activities, and visited with her relatives. However, she was lacking in spontaneity and seemed to weigh all of her remarks before replying. The family was pleased with her progress and with her behavior at home. She was placed on visit with her family and was followed in the outpatient department.

She appeared regularly for her appointments in the outpatient department but became progressively less responsive. After four months

she remarked that she saw the genitals of everyone she met. She also described a relationship with an older man in which she repeatedly performed fellatio on him at his request. This had occurred before her first hospitalization but had not been previously related. She was blocking, confused, appeared to be hallucinating and was readmitted.

Following her return to the ward she lapsed into a stuporous unresponsive state which lasted approximately one week and was only briefly altered by electric shock treatment. Without provocation she attacked another patient. Following this episode the patient would alternate between stuporous inactivity and unpredictable assaults on patients and personnel. Following a prolonged course of 60 deep insulin comas she again improved though to a lesser degree than formerly.

### *Acute Undifferentiated Type*

These are, as the term implies, acute states which show a great deal of turmoil and a variety of schizophrenic symptomatology which may clear within a few weeks. Depending upon the nature of subsequent attacks or if the illness progresses to a chronic state, the predominant symptomatology will determine how the illness should be classified.

A 20-year-old college student was admitted after he proclaimed himself Christ in the midst of a final examination and was perplexed, confused, and in poor contact. There had been no previous episodes.

He was somewhat rigid and before the acute onset had been more preoccupied than usual. Two years before while in high school he had suddenly quit the football team in the middle of the season because he had proven he could make the first team and could see no reason to play the rest of the season. According to the history, this decision was much more upsetting to the coach than to the patient.

When he was admitted he responded very slowly to direct questions. After entering the ward he expressed many bizarre ideas, all with a religious coloring, and followed this by an unresponsive period. During the next three-weeks period his perplexity gradually cleared. Although he was somewhat less than spontaneous, he again showed an interest in his environment and the following year again enrolled in school.

### PARANOIA

This group was termed progressive systematized insanity by Kraepelin. These patients were believed to form a "delusionary

view of the world"; as a result, happenings were no longer referred to the natural course of events, but to a deliberate and planned system, usually attributed to some one individual or occurrence. Paranoia was said to develop "without independent disturbances of emotional life or of the will" suspicions became certainties and then convictions which fit the delusional system. Hallucinations were said not to occur in such illnesses.

Such qualities as being "impervious to reason," having a weakness of understanding, and increased irritability, and an inclination to exhaustive and senseless action, to prove the validity of the delusional ideas, is characteristic of such patients. The lack or trivial injury to memory and mental vivacity, without a disturbance or destruction of volition, are felt to set these patients apart from schizophrenic paranoid reactions.

The conclusion that paranoia is a diagnostic entity is not universally held; some classify these very rare syndromes as forms of schizophrenic reactions.

*Paranoia* is classified as a very rare psychotic disorder in which a complex delusional system may be evolved which is isolated from normal thought. Hallucinations are not seen and the personality is relatively intact in spite of the chronicity of the illness. The system is slowly evolved and may be logically elaborated from the misinterpretation of an actual occurrence.

## OTHER TYPES

### *Paranoid State*

These patients show paranoid delusions which are not systematized as in paranoia. They do not deteriorate or show the fragmentation of personality that occurs in schizophrenia. These conditions are frequently of brief duration.

### *Schizophrenic Reaction, Chronic Undifferentiated Type*

These are chronic patients who show a mixed symptomatology which does not place them clearly in any one type of reaction. Those termed "incipient," "latent," and "prepsychotic" are also included under this diagnosis.

*Schizophrenic Reaction, Schizo Affective Type*

These patients show evidence of both schizophrenic and affective reactions. The mental content may be schizophrenic but a marked affective component is evident. Too the previous history may not be in keeping with the presenting symptomatology.

*Schizophrenic Reaction, Residual Type*

Those patients who during a remission following a psychotic episode, continue to show recognizable disturbances of thinking, affectivity, or behavior are classified here.

## *SOMATIC AND DRUG THERAPIES*

### Electroconvulsive Therapy

Method

Frequency and Number of Treatments

Indications and Contraindications

Side Effects

Modifying the Seizure

### Insulin Coma

Method

Stages of Coma

Complications

Indications and Contraindications

### Psychosurgery

Indications

Results

### Drug Therapy

Tranquilizers

Indications

Contraindications and Side Effects

Site of Action of Tranquilizers

Psychic Energizers



## *Somatic and Drug Therapies*

## ELECTROCONVULSIVE THERAPY

Von Meduna introduced the use of drug induced seizures in the treatment of schizophrenia in 1935. He first used camphor and later metrazol. In 1938, Cerlatti and Bini described the production of convulsions electrically.

The machine used in electroconvulsive therapy operates on 110-volt alternating current. The time and voltage necessary to produce a seizure are regulated. The voltage range is between 70 and 130, and the time between 0.1 and 0.5 second.

Kalinowsky and Hoch recommend an initial setting of 70 volts for 0.2 second. If a seizure is not produced, the voltage is increased and a second stimulus is given immediately, if this too, is unsuccessful, the time is increased and a third or even a fourth stimulus may be applied.

### *Method*

A complete physical examination and a roentgenogram of the chest and a lateral view of the spine should be done before treatment is initiated. In patients over 40 years of age, an electrocardiogram should be obtained. The treatments are given in the morning, either fasting or with a cup of coffee or a glass of fruit juice two hours before.

The physician should inspect the patient's mouth before inserting the rubber gag to be certain that all removable dentures or

chewing gum has been taken out. The patient voids and is then placed in a dorsal position on a well padded table. A small pillow may be placed in the small of the patient's back although the effectiveness of this effort in reducing compression fractures of the vertebrae is questioned.

The patient's arms and legs should be held, but they must not be rigidly held, some movement of the extremities should be allowed. Electrode paste is applied bilaterally to the forehead and the electrodes are applied. The jaw should be held firmly against the mouth gag to prevent the jaws' being dislocated.

When the stimulus is given unconsciousness is produced immediately. After the seizure when the respiration is resumed, the patient should be turned on his side to prevent his aspirating saliva.

#### *Frequency and Number of Treatments*

Treatments are given three times a week. In depression, between 8 and 12 treatments will usually be sufficient. If the patient is very disturbed two treatments may be given daily for two or three days. This is necessary less frequently than in the pretranquilizer days.

#### *Indications and Contraindications*

Electroconvulsive therapy is not a last resort after all else has failed. Neither is it a procedure to be tried in all the emotionally ill who do not immediately respond to psychotherapy. The patient should be followed closely during the course of the treatments to determine his progress, to answer his and the family's questions and to offer reassurance.

Weeks of psychotherapy or a suicidal attempt should not be required for the psychiatrist to determine whether the patient needs convulsive therapy. Depressions which occur without demonstrable external cause, or those in which the environmental provocation is minimal or incidental offer the most favorable prognosis with this method.

The manner in which this treatment is suggested to the patient and explained to his family may greatly influence the patient's acceptance of the treatment and the relationship with him after the treatment is completed. There is never an occasion to apologize

for the need for convulsive therapy but there may be a need to apologize at length for a suicide that treatment might have prevented

Electroconvulsive therapy is most effective in the treatment of depression. It is also of benefit in controlling the over active manic patient, the chronically ill disturbed schizophrenic or the patient in schizophrenic turmoil.

There are few contraindications to electroconvulsive therapy. Cardiovascular disorders which might be aggravated by the activity of the seizure would contraindicate its use. Active tuberculosis or recent fractures also contraindicate this method.

In determining whether the patient's physical condition is a contraindication, the physician has to consider the effects of the patient's over activity if untreated on the disability. For instance a 58 year-old male with a history of coronary artery disease was actively suicidal and in such an agitated state that electroconvulsive therapy seemed less a hazard than allowing him to exhaust himself.

### *Side Effects*

Electroconvulsive therapy produces disturbances in memory. These disturbances are usually minimal and clear up within a few weeks following treatment. There is no indication that any lasting intellectual impairment is produced by electroconvulsive therapy.

Dislocations and fractures may occur but are less frequent when the seizures are modified and the force of the muscular contractions is decreased. Compression fractures of the vertebrae are the most common side effect. The apnea and the increasing cyanosis following the seizure are disturbing to witness. However, about the time the physician decides to initiate artificial respiration the patient (and the physician) breathe spontaneously.

### *Modifying the Seizure*

Succinylcholine dichloride (Anectine) in a dose of 10 to 40 mg intravenously is widely used as a muscle relaxant in electroconvulsive therapy. This preparation is very brief in its action depending on the amount given either a total paralysis or a decrease in the force of the seizure may be produced.

An airway, oxygen with a mask and bag to allow for positive pressure, and a suction machine should be in the room where the treatment is given. It is wise for the physician to check the oxygen before giving the treatment just to be certain that the tank is not empty, that he knows how to work the machine, and that all the valves can be turned.

A mixture in the same syringe, of succinylcholine dichloride (19 to 40 mg.), Pentothal (2 ml.) and atropine (0.8 mg.) given intravenously has been recommended to modify the seizure. Between 10 and 20 mg. of succinylcholine dichloride may be used alone to "soften" the seizure; with this amount respiration will usually be resumed spontaneously when the seizure is completed. Oxygen should always be available if it is needed.

Those giving electroconvulsive therapy should be taught how to insert an airway by a qualified anesthetist. Any resistance to pressure on the oxygen bag does not call for more pressure, but an immediate search for an obstruction.

### INSULIN COMA

Sakel found in 1928 that insulin was beneficial in controlling the excitement seen in morphine addicts during withdrawal. He concluded insulin might also be effective in the treatment of other excited states and in 1933 reported encouraging results in schizophrenia.

Since the introduction of the tranquilizers, insulin is less frequently utilized than in the past. It is an expensive procedure which requires a great deal of supervision by trained personnel to be safely carried out.

#### *Method*

Sakel's suggestions are still followed in inducing coma. The procedure is to give 15 to 25 units of regular insulin intramuscularly early in the morning with the patient in a fasting state. The dose is increased by 10 to 15 units daily until the patient goes into a coma; this usually requires between 100 and 300 units. If the patient does not go into coma on 300 units, a "zig-zag" procedure may be tried

in which twice the original dose is given the first day, half the maximal dose on the second day and the maximal dose on the third day. The treatment is given five or six times a week. A course of insulin treatment consists of an average of 50 hours of coma.

The patient is left in the coma for one to one and one half hours. The coma is then terminated either by tube feeding with 500 cc of 50 per cent glucose, or by 20 to 50 cc of a 33 $\frac{1}{3}$  per cent solution of glucose intravenously.

### *Stages of Coma*

In the precoma (or preshock) phase muscular relaxation and increased perspiration and salivation occur. As the hypoglycemia continues, the patient may be confused and poorly coordinated; there may be muscular tremors and twitching.

The patient may be considered in coma (or shock) when a loss of consciousness occurs. This usually begins about the third hour of hypoglycemia. As the coma deepens an increased hypertonus with spasms and positive Babinski are noted. With time, the extensor spasms become more marked; there is a loss of sensitivity to external stimuli; the corneal reflex is lost and muscular flaccidity is noted.

### *Complications*

The mortality in this form of treatment is between 0.5 and 1.0 per cent.

The most serious complication is a prolonged or irreversible coma. If the patient does not respond within five minutes to intravenous glucose or in 20 minutes to gastric feeding, he is considered to be in a prolonged coma.

This is treated first with 100 cc of 33 $\frac{1}{3}$  per cent glucose and 100 mg of thiamine HCl to aid in its metabolism. If no response occurs within 15 minutes, 50 cc of 50 per cent sucrose are given as a dehydrating measure. If the patient has still failed to respond, 50 cc of doubly concentrated human plasma is tried. Patients who expire in a prolonged coma show degenerative and hemorrhagic lesions as well as edema of the brain.

After shock or secondary coma may occur within twelve hours.

after recovery; this is treated by giving carbohydrate either orally or intravenously. Respiratory complications include aspiration pneumonia and pulmonary edema which is usually of cardiac origin. During the coma, the patient's pulse and blood pressure must be taken repeatedly.

### *Indications and Contraindications*

Insulin is most effective in the younger, excited, agitated schizophrenic of paranoid or catatonic type who has been ill for less than a year.

The presence of an infectious process, systemic illness, or inadequate superficial veins contraindicates the use of insulin. Also, this method should not be used in patients under 16 or over 45 years of age.

### PSYCHOSURGERY

Moniz, a Portuguese neurologist, developed the prefrontal lobotomy in 1936. Freeman and Watts have most widely advocated its use in this country.

The technique consists of severing the frontothalamic fibers. This may be done as an open procedure, "blind" through burr holes, by cortical undercutting, by removing selected areas of cortex (topectomy) or by coagulating the dorsomedial nucleus of the thalamus (thalamotomy). The transorbital procedure consists of driving an instrument through the superior surface of the orbit 2 cm. posterior to the frontal sinus following two electroconvulsive treatments. It seems the response is related more to the quantity of brain substance destroyed than to the area involved.

### *Indications*

Agitated, anxious, or belligerent schizophrenic patients who have been ill for a year or longer and who have been refractory to other procedures including tranquilizing medication and electroconvulsive therapy, should be considered for this procedure.

Agitated patients with involutional melancholia who do not respond to the electroconvulsive therapy, and patients with chronic obsessive compulsive reactions which are accompanied by disabling tension may also be considered for this procedure.

### *Results*

For seven to ten days following surgery the patient is in a state of irritable apathy. He is usually incontinent and has to be persuaded to dress himself or visit the toilet. There is a marked increase in skin sensitivity which will be evident in attempts to bathe the patient or give hypodermic medication. Postoperative seizures may occur as a complication.

If he is paranoid he will usually deny that he has had an operation. The patient has a marked decrease in self-concern following the procedure and may express himself rather vividly. Improvement in the patient's social behavior may continue for months after the operation, particularly in those who had made a satisfactory adjustment before their original illness.

Psychosurgery is a procedure which is indicated only for the patient whose illness is drastic and who has not responded to previous therapeutic efforts. In schizophrenics refractory to other treatment procedures, several studies have shown the following: one third of the patients markedly improved, one third showed slight improvement, and the remainder were unchanged.

## DRUG THERAPY

### *Tranquilizers*

This apparently is the age of lost tranquility, judging from the number of these medications being prescribed. It should also be noted that a very high percentage of these prescriptions are written by physicians who are not psychiatrists, and from this it might be concluded that psychiatrists see only a small percentage of those treated medically for emotional difficulties.

It might be asked: What is this tranquility so many seek?

Tranquility is a state of calm, serene composure free from disturbance and accompanied by wakefulness. It is a state certainly to be desired in self but not so appealing in one's employees. Culturally we hope tranquility rather than confusion will be our lot as we become aged; this same tranquility is not regularly admired in the younger, rather they are taught to be anxious, competitive and concerned.



This is more an anxious than a tranquil age. The tranquility of the first 50 years of life may be continuously interrupted by concern over the last 15. We seek sufficient security to anticipate any unforeseen misfortune, from sickness to our own demise. Such concern for the future provides a sustained market for, at least, a transitory tranquility.

Of course, man had tranquilizers several centuries before he realized the phenothiazines had derivatives, he found that alcohol made him unconcerned, calm, and serene, to the point of stupor.

The quality which produces an uncomfortable nontranquil state is anxiety or tension. It might follow that the tranquilizers would then be indicated for the same types of patients who, in the pretranquil past, might have been given phenobarbital, in essence this is correct. The tranquilizers are indicated for the excessively and uncomfortably anxious or tense patient.

#### INDICATIONS

Therefore, the presence of anxiety or tension should be the first consideration in recommending these drugs. The existence of an anxious state is considered in those obviously tense as shown by agitation, restlessness or increased motor activity (and euthyroid).

Anxiety is also to be sought in patients with evidence of an over active or unstable autonomic nervous system. Finally, patients with undue concern over somatic complaints which cannot be substantiated by a thorough physical examination merit an appraisal of their emotional status—particularly if they are disturbed by insomnia, anorexia, fatigability, and emphasize the fact they have never been nervous.

It must be stressed that this is an empirical approach, the tranquilizers only control the symptoms; they do not effect the cause. Such treatment is comparable to aspirin in those who have fever, similarly, if the cause of the tension or the fever is self limiting, the treatment is quite effective. They are apparently well tolerated over prolonged periods of administration.

The tranquilizers offer some patients relief from an extremely uncomfortable state, but they will not make the patient's wife more responsive, his neighbor less annoying, nor his employer less demanding. They may decrease his response to these irritations.

## CONTRAINDICATIONS AND SIDE EFFECTS

Presently, there is general accord that the tranquilizers are contraindicated in the depressed. This applies particularly to reserpine. Bone marrow depression occurs in some patients who receive the tranquilizers, and the development of a leukopenia is sufficient cause for discontinuing the medication. This bone marrow depression may not be evident until after three or four weeks of treatment, and those given these preparations over a prolonged period should have a leukocyte count once a month.

Grand mal seizures have been reported, as well as jaundice, extrapyramidal symptoms, hyperpyrexia, and allergic skin responses. A reduction of the dosage or a discontinuation of the drug is indicated if the side effects are severe.

The decision over the side effects, particularly with the phenothiazine derivatives, depends on the therapeutic response; if there is marked clinical improvement, a temporary reduction to a lower dosage level should be considered rather than discontinuing the medication.

In evaluating the effect of these compounds on mentally ill patients, the most frequently seen complication is the development of extrapyramidal signs. This usually begins with fatigue, muscular weakness, and "cogwheel" rigidity. If a therapeutic response has not been obtained and the dose is raised, within a week the patient shows a loss of facial expression, excessive salivation, and he may complain of difficulty in swallowing and feeding himself.

In some patients there appears to be a relationship between the degree of disturbance and the rapidity with which extrapyramidal symptoms develop. Also, the larger the doses, the greater the likelihood of the extrapyramidal involvement. One of the more recently introduced compounds (Mellaril) reportedly causes fewer extrapyramidal effects than previously available phenothiazine derivatives.

Finally, comes the question of dosage. It would seem wise in the patient who is not psychotic, to begin with the minimum recommended dosage of the particular tranquilizer being used and to increase it during a 4- to 6-week period to the maximum recommended if improvement does not occur. If improvement does occur (that is,

if the patient becomes more tranquil, less concerned, and more at ease), the dose should be held at this level. How long should one prescribe a tranquilizer before becoming discouraged? In the non-psychotic, six weeks would seem an ample trial, since six weeks without improvement is about the maximum most nonpsychotic patients will tolerate anyway.

In the disturbed psychotic patient, the phenothiazine derivatives may be quite effective in decreasing over activity and quieting turmoil. Also, the response in some paranoid patients is very encouraging. They may also make the patient much more accessible to other types of therapy.

Presently, there seems to be little difference in therapeutic response to different phenothiazine derivatives. On the other hand, some patients seem to tolerate one phenothiazine better than another and the least toxic compound is preferable.

When these compounds were first introduced Delay pointed out that those patients who would respond, usually responded as well to a moderate dose given over a two or three week period as they did to a heroic dose during the first few days. This moderate dosage approach is less likely to produce side effects than the routine use of massive doses of these compounds.

In the psychotic patient the type of illness should determine how long the patient continues to take the medication. If a young patient has an acute episode it would hardly be rational to suggest he continue to take a tranquilizer the rest of his life. Similarly, a patient whose history shows he has had one or two episodes during his life, might be able to avoid hospitalization by taking a tranquilizer at the onset of any subsequent difficulty. This certainly would not be sufficient cause to recommend that he continuously take a phenothiazine for four or five years on the presumption he might have another episode.

The chronic patient whose behavior is sufficiently controlled with these medications to permit discharge from the hospital will probably require the drug permanently. This fact should be emphasized to the patient and to the relatives.

A 38-year-old female patient diagnosed schizophrenic reaction, cata

tonic type, had been hospitalized 9 years. She was previously refractory to electroconvulsive therapy and insulin coma.

She rarely responded to direct questions and spent her days endlessly pacing up and down the hall. While taking a phenothiazine derivative, she became more alert, responsive, and friendly. Her pacing decreased and she was able to participate in some activities.

After awhile she was tried in a supervised job outside the hospital. She was still schizophrenic but she was much less disturbed and tolerated the medication very well.

In order to try a different type of treatment the patient's medication was discontinued. She did not respond and within two weeks she was in a catatonic stupor.

Unknown to the patient or the ward personnel a placebo identical to the medication was substituted without effect. When the active preparation was started, she again responded.

The patient has been on this particular drug for over a year and has maintained her improvement. The need to continue the medication after discharge was repeatedly emphasized to the patient and her relatives.

The rapidity with which these similarly acting compounds are being introduced makes it difficult to recommend one in preference to the others. It would appear that the position of these compounds in the routine treatment of the emotionally ill is not yet established. Until one or more of the available preparations is clearly more effective and less toxic than the others the practitioner will have to use his clinical judgement in deciding which is most suited to the individual case.

#### SITE OF ACTION OF TRANQUILIZERS

A recent review of the reports on the neurophysiological effects of the tranquilizers by Unna concluded that "convincing neurophysiological evidence for the action of reserpine and of chlorpromazine is not yet at hand." However, the following determinations have been established:

Meprobamate has a mephentesin like action causing depression of the internuncial neurons in the spinal cord and the bulbar reflex regulating centers. Meprobamate also has mild anticonvulsant

properties and little if any effect on autonomic function, either peripherally or centrally.

Unlike sedatives, the tranquilizers do not produce ataxia, anesthesia, excitement, or any pronounced tendency to addiction. They also differ in that they increase muscle tone and lower the seizure threshold.

### *Psychic Energizers*

The first "psychic energizer" was iproniazid (Marsilid); this product and drugs with similar actions are classified as central nervous system stimulants. They are recommended for the treatment of depression.

Although the precise mechanism of action of the "energizers" is unknown, it is presumed to result from their inhibition of monoamine oxidase. Monoamine oxidase is an enzyme involved in the metabolism of serotonin, epinephrine, norepinephrine and other active amines.

Kline originally reported the drug as being effective in a group of 17 chronic psychotic patients from a state hospital population (presumably schizophrenics), and 9 private patients. Presently, the drug is recommended primarily for psychotic depressions. Recently, it has not been advocated for the treatment of schizophrenics.

Iproniazid was first used in the treatment of tuberculosis but was found to be too toxic for routine use. The side effects are many and include postural hypotension, vertigo, clonus, tremors, parasesthesias, to list a few; but the most serious is the development of a hepatitis.

The place of monoamine oxidase inhibitors in the treatment of depression is not yet clear; neither is it certain whether their effects result from an accumulation of serotonin or norepinephrine. Until better understood, it would seem wise to use the "psychic energizers" with the fewest side effects.

*CHILD PSYCHIATRY*

## Causes of Emotional Difficulty in Children

External Environment

The Family

Excessive Domination

Insecurity in the Mother

Domineering Mother

Pre-existing Parental Ideal

Affective Neglect

Immature Parent

The Peer Group

Internal Environment

## Types of Reactions

Adjustment Reactions

Habit Disturbance

Thumb Sucking

Nail Biting

Enuresis

Masturbation

Conduct Disturbance

Neurotic Traits

Psychoneurotic Reactions

Hysteria

Psychotic Reactions

Early Infantile Autism

Childhood Schizophrenia

Treatment

## *Child Psychiatry*

Psychotherapy

    Psychoanalytic Approaches

    Play Therapy

    Brief Psychotherapy

Procedure in Evaluation

In this chapter the effects of environment on the child and the types of reactions seen in children are described. These problems are considered from the viewpoint of the practicing physician who has the responsibility of diagnosis and treatment and who may lack the advantage of having ancillary personnel.

The procedures (administrative and therapeutic) followed in child guidance clinics are described in detail in monographs on this subject and are not pertinent to this section. Too, the development of the personality is covered in the chapter on psychodynamics and will not be repeated here.

In 1909 Healy undertook an organized study of childhood behavioral disorders. Later, the concept of a "team approach" to child guidance was evolved, the "team" originally consisting of a psychiatrist, a psychiatric social worker, and a clinical psychologist. The responsibilities of the members of the team varied but the primary concern of the psychiatrist was therapy, of the social worker, the parents and of the psychologist, testing and research.

Due to the extended period required for a child to reach maturity and independence, there is an increased vulnerability to the influence of his external environment, particularly the meaningful members of his family. He also lacks one of the methods of avoiding conflict available to adults, namely, removing himself from the disturbing situation. The child cannot divorce himself from the incompatible family as one of his parents may have done from a disturbing



spouse, nor can he quit school because he finds the teacher difficult to work for.

The influences of the external environment are modified as the world the child perceives, and his responses, alter with growth; and those elements which may have been disturbing at one period may spontaneously become less so at a later age.

## CAUSES OF EMOTIONAL DIFFICULTY IN CHILDREN

### *External Environment*

#### THE FAMILY

The particular balance which a parent should achieve between restriction and license which allows his offspring the correct degree of spontaneity while being trained has not yet been described; and since this is more an affective than an intellectual balance, there is little likelihood that any "cut and dried" procedure will be evolved.

A parent is hardly an affectless entity who is the same on each succeeding day, and whose every response to the child is intellectually weighed before being expressed. Parents and children alike become fatigued, irritable, and on one day or at one hour will be more permissive and less bothered than at another. Consequently, behavior which a parent may on one occasion accept may on another provoke punishment. This the child with an average endowment of empathy senses, appreciates, and utilizes to the fullest.

Other people who have children may show persisting deviations or exaggerations of behavior which are detrimental to the emotional development of the child. Parents may provoke an adjustment reaction by excessive domination, by affective neglect, or by their own immaturity.

*Excessive domination.* Insecurity in the mother. The first and most enduring group with which the child has contact is the family. The mother is ordinarily the member with whom the child has most contact, and she presumably exerts the greatest influence. The time spent with the mother should decrease continually following delivery. If this increasing separation is not permitted the child is not maturing emotionally. Adler pointed out that a mother may be satisfied with her child's restricted social development and show little

concern over the fact ' he must go from her care into a much wider circle of human contacts ' The mother may try in various ways to prevent the child's ' growing away from her

These efforts may frustrate the child and adjustment reactions may result, but of more eventual concern is the compliant youngster who accepts this infantile status without rebellion. Fortunately, this symbiosis may be interrupted by the child's entering school.

A mother may dominate a child (particularly the first born) as a result of her own anxiety and uncertainty. She may lack self-confidence, fear she will err and be too strict or too permissive, and she will certainly not want for warnings from authorities (?) ad infinitum on the hazards of motherhood.

Such an anxious mother may become fearful when her child is out of sight or hearing and if he cannot be immediately located the worst is presumed and the apprehension becomes panic. Some of this apprehension may be transmitted to the child when he is located or it may be dissipated as hostility when the child is found unharmed, intact, and not too interested. Unfortunately such an episode is too often followed by greater restrictions and closer surveillance. A part of this concern may arise from unconscious hostility but reality cannot be denied, too many children die each day from an impulsive dash into traffic, or drown in an unguarded moment.

If the mother does not gain confidence in herself and the child as he grows older more active and more difficult to contain they may both be frustrated. The child rebels as best he can by taking most of his food between meals and by disappearing at every opportunity. The home life may be an extended series of crises since the child either cannot be found or if found cannot be fed.

A young mother is seen who wants to discuss her child's behavior and to gather information to use in the arguments with her husband over how the boy should be raised. She had an over active son of five years, who was described as the terror of the neighborhood. Whenever he had a chance the boy dashed out the front door toward the street with the mother in hot pursuit. This was followed by a talking to and threats of spanking. He had always presented an eating problem but appeared well nourished, energetic and sound of limb.

The mother was extremely tense and had taken to locking the boy

in his room during his nap time, so she could get on with the housework. The father felt the raising of the child and the running of the home were her responsibility although he had a few critical suggestions to offer about everything she did. He would criticize, she would become tearful, the husband would become "disgusted with the whole mess," and the child would not eat.

### The domineering mother.

In other instances, a domineering wife becomes a mother and assumes the same domineering aggressive attitude toward her child that she has toward all other people. She is quite "positive" in her thinking and in her convictions; she "knows" what is best for the child. Since such a mother is usually too formidable for an infant to oppose, the child may assume a passive attitude not only toward his mother's insistence but toward others he meets; or he may seize every opportunity away from home to release as much aggression as possible before he reluctantly returns.

**Pre-existing parental ideal.** A parent may dominate a child in an effort to make him conform to a pre-existing ideal. This is an exaggeration of the usual desire that parents have for their offspring to excel (and to reflect a little glory in the process). As a rule this desire abates if the child consistently shows a lack of interest or ability in fulfilling the parents' ambitions, and he is allowed to follow his own bent.

However, some parents carry this demand to comply with their ambitions to interfering extremes. A child may be dressed differently from the others and find himself the object of ridicule or hostility. The child's wishes may be ignored and he may not be allowed the freedom others his age enjoy; his friends walk home from school but his mother comes after him to his embarrassment.

The demands made may be so excessive as to be anxiety provoking. The ideal the parents hold may more nearly resemble a well-mannered adult than a spontaneous youngster. For instance, a child may be taught that anger is wrong or that he must not even think "bad thoughts"; but he unfortunately finds that his peers are not philosophers and that they not only have "bad thoughts" but they may even use "bad words" with a certain facility, even in grammar school.

*Affective Neglect* Children require affection, attention and praise, as well as vitamins, and a deficiency of either may produce symptoms. The patterns of gaining attention at home may be followed at school and later in life.

A child may not receive sufficient attention and interest because the parents are immature or because they simply are unable to show affection. For instance, a father who cannot comfortably display affection may express his interest in constant criticism or endless complaining over each bill he has to pay. The greater his interest, the greater his criticism.

A 21 year-old girl is seen who attributes many of her difficulties to her unending arguments with her father. She is an only child and the father is quite successful.

From the time she began dating the father always waited up for her to return home in the evening although he never admitted that her being out was the reason he was still up. He never questioned her activities or behavior when she returned but always had a handful of bills ready to discuss with her. When she was younger there had been similar bickering about her grades. In spite of his complaining the father was overly generous.

Another type of affective neglect results when one child is a repeated source of concern to the parents and requires an excessive amount of their time and interest. A second child in the family may attempt to gain recognition and affection by an opposite attitude of total obedience, by an obvious attempt to be good or, in essence, to be as unlike the troublesome sibling as possible.

Unfortunately, this passive attitude seldom succeeds for the compliant child, since his predictable obedience is soon accepted with little notice by the parents and becomes too routine to merit praise. The compliant sibling may be literally trapped in his role of the "good" child since to become angry, hostile or rebellious would be to act in the same manner as the sibling with whom he is unable to compete. This second child's passive attitude may be increased by the fact he is younger, physically less able, or more sensitive than his disturbing sibling.

There are children, a sizeable number in fact who prefer peace to turmoil, who are reluctant to risk failure by competing and who

seldom experience the pleasure of aggression. Such traits may be exaggerated by the existence of aggressive, demanding, argumentative parents or siblings.

An attitude of passive obedience, once adopted, is not easily altered. The more habitual this manner of gaining praise by obedient acceptance becomes, the more a passive, peaceful attitude is relied on as a pattern of behavior and method of meeting all conflict. The child literally fails to learn to express anger, aggression, or hostility. An adult with such a background is unable to suddenly abandon a life long pattern of acquiescence and is prone to imposition which he tolerates and anxiety which he does not understand.

*The Immature Parent* Immature behavior is usually considered behavior that is out of keeping with an individual's age, background, or experience. A parent may reveal his immaturity by a failure to assume responsibility for himself, for his spouse, or for his children.

Some parents provide most adequately for a child's material needs but are negligent in failing to show individual interest or attention in the youngster. The other extreme is the parent who gives most generously of his time and interest but little else to the family. Either extreme tends to produce feelings of insecurity in the child.

Horney felt the failure to consider a child as a particular individual and to provide the required affection created basic anxiety in him. This inability to provide emotionally for the child arises from the parents' preoccupation with their own neuroses; consequently, the youngster feels isolated and without status in a competitive and hostile world.

The girl or boy may be an inactive but anxious observer of their parents' continuing arguments, or they may be asked to inform on one parent or the other and thereby participate in the arguments. Children trapped between two such parents may exist in a state of continuing apprehension. They may early cease to be spontaneous to avoid the possibility of initiating disagreement. There would appear room for serious doubt as to the benefit to the child of maintaining such a marriage to provide him a residence.

An alcoholic father's unpredictable behavior may cause a continuing anxiety in a child as the family waits apprehensively from

the end of one bout for the beginning of another. An alcoholic mother may be a particular source of concern to a daughter. This is well illustrated by a patient who restricted her friendships and socializing in high school and college because she was always fearful of bringing a friend home and finding her mother in an alcoholic stupor. She would refuse invitations to her friends' homes, because they would in turn expect either an invitation or an explanation from her.

The only requirements for parenthood being fertility and the opportunity to exercise the talent, the added responsibility of a child seldom provokes the irresponsible to maturity. The narcissistic mother may resent the disfigurement of pregnancy and make the trauma of delivery the focus of her subsequent hypochondriacal complaints.

This narcissism is obvious in the mother who treats the child as a part of self rather than as another independent human. The daughter is dressed and displayed at every opportunity to attract praise to the mother. The situation is similar in the parent with the intellectually superior child who has an insatiable need for the youngster to excel.

#### THE PEER GROUP

Adler's statement that "social interest is the barometer of a child's normality" and his stress on the importance of the development of social feeling are well remembered. The importance of a child's status with his contemporaries probably increases as rapidly as the development of his ego. There is no doubt of the influence of the family and his relationship with his mother, but the problem of establishing himself with his contemporaries, of gaining security in a group of his own age, remain his problem to solve.

The family is usually much less critical of a child's shortcomings than his peers, who are more apt to ridicule, tease, or reject. The very qualities praised by the family may make the too correct youngster the butt of his group's hostility. Ordinarily, the child has status in the family by the mere fact of being a member; but his position with his equals must result from his own efforts and their judgment. The boy who is unable to balance what he is taught at home and

the disregard those of his own age may show for these teachings may have a problem. If he is inadequate in competition with his peers he may refuse to play; he may deny his interest in the group or he may attempt to reassure himself at the family's expense by being irritable, petulant, or rebellious. The most undesirable solution is to avoid failure by withdrawing or by becoming disinterested and seeking satisfaction in phantasy.

A child who fails in his peer group, who is uncomfortable and unable to play, may return to the security his mother previously offered and, in essence, seek to be dominated. The boy who is too rigid, stubborn, and unbending to make the compromises his group demands and progressively isolates himself as he continues through school is having trouble in an area in which the parents cannot enter. By adolescence such a boy may be considered odd and peculiar by his contemporaries.

The history may show he has always "preferred the company of older people," which he certainly may have if he was uncomfortable with his own group. If a youngster spends too much time alone or with older people he may lose the ability to communicate with the others in his age group. He is then faced with the problems of adolescence without the security and information the group draws from itself.

Helen was seen when she was 19 years of age. She had a splendid scholastic record until her sophomore year in college. She then appeared preoccupied, failed to attend class regularly, and finally was returned home after writing a very confused test paper. Her history revealed that since childhood she had considered herself peculiar and undesirably unlike other children. Her mother stated: "She would play alone for hours and was always a 'little lady' and never acted silly like other children."

### *Internal Environment*

It has long since been pointed out that an individual chooses his trauma as well as his pleasure, and what may be traumatic to one may go unnoticed by another. The child who experiences the event gives it value, and his evaluation of its meaningfulness determines his manner of response, and whether the activity is consciously

tolerated or is repressed. Therefore what occurs in the environment has significance according to its meaningfulness to the patient.

The elements of a child's internal environment that determines his response are not so available to measure and examination as the factors which make up his external world, but they are of equal or greater importance in understanding behavior. Since significance is individually determined, a system of preconceived generalities offers little help in treatment.

Physical abnormalities which may interfere with a child's progress and function are not always obvious, particularly difficulties in visual and auditory perception. Such factors as a reading disability or word blindness may be misinterpreted as retardation and may account for some disorders of conduct. A defect in sight or hearing may similarly be overlooked unless routinely sought. There can be no substitute for thorough examination, attentive listening and careful observation in the evaluation of a patient's internal organization.

## TYPES OF REACTIONS

### *Adjustment Reactions of Childhood*

These reactions are confined to transient symptomatic responses to immediate environmental or internal disturbances, as opposed to more prolonged and definitive reactions. Excessive demands at home, at school, or from within are acting on the child to produce tension and anxiety. A reduction in the excessive demands which disturb the child will be followed by a remission in the symptoms.

### *Habit Disturbance*

#### THUMB SUCKING

Children who persist in sucking the thumb or fingers as they grow older may do so only when hungry, weary, sleepy, or bored. As Kanner points out, this habit, although known to the ancients, was of little interest before warnings from alarmists in the ranks of dentists and psychologists gave it meaning and importance.

Some children suck their thumb each night before they sleep, others while they read or watch television, and they appear tranquilized and contented with the activity. A callous may develop on



the preferred thumb and abrasions of the skin may occur. The past warnings of harmful germs gaining entrance to the mouth by way of the thumb are no longer fashionable.

Treatment is aimed at decreasing parental concern, and relieving any excessive demands being made on the child. A substitute in the form of some other satisfying activity or interest to replace the thumb sucking should be sought. Punishment is not effective. De-emphasizing the habit by praise, attention, and interest in the child's other activities may be beneficial.

Not infrequently after the child starts to school the thumb sucking is discontinued during the day due to the pressure of his group, although it may be continued at home. If the child who sucks his thumb is somewhat a leader in his group, a few others in kindergarten may briefly resume the activity, to the concern of many parents.

#### NAIL BITING

Unlike the thumb sucker who appears content in his activity, the nail biter is obviously tense and is more apt to indulge when in anxiety-provoking situations. Some children bite their nails before tests, during classes with certain teachers, or in any tension-producing situation.

This is probably the most widespread habitual method of releasing tension utilized by children and adults. Threats and punishment are not the answer; if the nail biting is considered a method of release of excessive tension, the individual should be encouraged to be more spontaneous, that is, to be less reserved or self-contained, to prevent the tension's accumulating.

An energetic youngster may be expected too early in life to be reserved, poised and not to "fidget" or "wiggle around"—these artificial restraints merely block other motor activity and increase his nail biting. The child's routine at home should be clarified to determine if he is given an opportunity to expend his energy in play or if he is being frustrated by unnecessary restrictions.

#### ENURESIS

Usually a child is able to keep himself dry by his third year. The enuretic is a persistent bed wetter after the third year. The prob-

lem is more frequent in boys than girls and is usually nocturnal but may also occur during the day

Diurnal wetting most frequently happens during moments of marked emotion particularly when the child is overcome with laughter, excited at play or is suddenly startled or frightened. Enuresis like other disorders cannot be categorically considered a detailed knowledge of the behavior of the enuretic patient must precede medical judgement

An otherwise well adjusted 8 year-old boy who was periodically enuretic was started on an involved study by his mother's reading a column in the lay press on the meaning of bed wetting. Subsequently the mother took the boy for a number of psychological tests which he rather enjoyed and a few interpretations which his mother did not enjoy. This was followed by an electroencephalogram which was not unusual. A copy of this report and the psychological findings were sent to the boy's pediatrician who was somewhat stimulated over the mother's activities and her using him as a referral source without his knowledge.

The history revealed the boy was usually enuretic after he stayed up later than his usual bed time because of visitors to see some particular television program or other interruption of the usual routine and was allowed extra fluid usually a carbonated drink at this hour. The combination of excitement and stimulation from the drink delayed his sleep after he was finally put to bed and two or three hours later he would wake up wet.

There was no need to restrict the boy's fluid intake except for the carbonated drink and the mother was advised to wake him on these special occasions when he was up late. This seemed more beneficial for the patient than setting a fixed time for him to retire in view of the mother's concern and the infrequency of the wetting. The pediatrician concluded that the newspaper article on enuresis which provoked the mother's activities was perhaps the most expensive literature she would ever have occasion to read.

The home situation the sleeping arrangements and a history of enuresis in other members of the family must all be clarified. Punishment and ridicule are never effective but reward and recognition for success are helpful. In the older child waking him for a trip to the bathroom may avoid wetting.

The motivation to cease to wet must come from the child when the etiology is psychogenic in nature. The management of the pa-

tient will be determined by the circumstances. If the patient is passive and shows other evidence of emotional disturbance, the parents should be encouraged to allow him more independence and responsibility.

The patient should actively participate in the efforts to overcome the enuresis, he should be encouraged to restrict his fluid intake, and if he is old enough setting the clock to insure his waking should be his job.

Too often, the child is brought into treatment as though he were a disinterested observer. He is discussed, examined, and may be given medication without his own attitude over the problem—or whether he even sees the enuresis as a problem—being clarified. The influence of the child's motivation is well illustrated by his frequent ability to remain dry throughout the night as a response to a reward.

#### MASTURBATION

Masturbation is no longer considered a cause of mental illness by the medical profession but this conclusion is not shared by nearly all the laity. An infant may explore his genitals as well as other parts of his anatomy, and his curiosity about the opposite sex will increase along with his curiosity about all things in his environment. Between the ages of four and seven he will probably make some efforts to compare himself to others. If he is apprehended in these efforts there may be undue concern in the minds of the parents and an increased interest on the part of the child.

A resumption of masturbating activity in the male at adolescence may be presumed. If the parents are advised that the practice is practically universal among males and will not result in any physical or mental disturbance, they will usually be reassured and relieved. If the parents are unduly concerned then their worries should be heard out in detail since there is little need to treat the adolescent for the parent's anxiety. Nocturnal emissions should be similarly discussed when they are of concern.

#### CONDUCT DISTURBANCE

As the term implies, these are conflicts with others as a result of the child's conduct in the home, school, or community, or in all

three areas. Such acts as stealing, destructiveness, cruelty, truancy, and running away are included.

The abnormality is not determined solely by the act but as well by a tendency to repetition, impulsiveness, purposelessness, and a disregard of the consequences. Such factors as brain damage and mental deficiency must not be overlooked. A lack of concern over being apprehended or the results of being 'caught,' with little apparent guilt or self-criticism, is a frequent finding in such children.

As in any other disturbance, the factors influencing the child must be determined. The parents' attitude toward the behavior, and whether they sought help because of their own concern or because of school or community pressure should be ascertained.

One study showed that although most young offenders are seen by the courts between the ages of 15 and 17 years, a third of those seen gave evidence of difficulties in adjustment by their eighth year and all but a few had trouble before they were eleven.

been able to socialize and appeared for the interview more from curiosity than concern over the boy's behavior

### *Neurotic Traits*

Transient reactions manifest as physical or emotional symptoms are classified in this group. Such reactions are related to habit disturbances and a differentiation may be difficult. Tics of organic origin are not included here. Neurotic traits include habit spasms, phobias, stammering and tics of psychogenic origin.

### *Psychoneurotic Reactions*

Children in whom anxiety exists to a marked degree for a prolonged period without a demonstrable situational conflict may show definitive disturbances which are classified as psychoneurotic reactions.

### HYSTERIA

The emotional nature of dissociative reactions in which fugue states, stupor, or amnesia occur is usually evident, however, the basis of conversion reactions is not so readily apparent.

In conversion reactions in children, when the only complaint is of physical disability or pain and when there is no evidence of anxiety, some obscure organic cause rather than hysteria may be erroneously suspected. Hysterical symptoms occur in children as well as adults and are more often treated by the family physician or pediatrician than the psychiatrist. If it is concluded that the child is too young or is not sufficiently nervous to have physical symptoms of emotional origin, the clinical picture will be confusing indeed.

The symptoms in hysteria show the following characteristics: they are not anatomical in their distribution, they offer the patient secondary gain either in avoiding an unpleasant situation or by gaining attention, and they interfere with the function of the involved part.

The hysterical personality is discussed in Chapter 6. In a child with atypical symptoms for which no adequate physical cause is demonstrable, the circumstances which preceded the illness should

be determined in detail. If the child is seen alone and is allowed to describe his play, others in the family and his school the reason for the symptom may become apparent.

If the hysterical basis for the complaint is not suspected and the pain or disability persists some minor and unrelated physical finding may be treated vigorously to little avail. Such causes as 'worms,' "mild anemia" or avitaminosis may be blamed; this conclusion is a source of relief to everyone but the patient.

The child's history, personality, and the contradictory physical findings rather than the age indicate the diagnosis.

A 14 year-old girl is seen because she is suspected of having paralytic poliomyelitis. The mother stated with some pride that her daughter had survived two previous bouts of polio: first at age 9 and the previous summer at age 13. The patient's menarche occurred a year earlier and she appeared sexually mature.

The neurological examination was not unusual; she had apparently recovered completely from her two previous paralytic episodes since there was no evidence of atrophy or muscular weakness. However when she attempted to walk her gait was unsteady and she required her mother's support and encouragement although she had climbed a flight of stairs to the office without assistance.

When the mother and the patient were told that no evidence of poliomyelitis could be found both were somewhat less than pleased. It was later learned the patient was hospitalized the same day by another physician for poliomyelitis. After a week in the hospital the patient made a sudden and dramatic recovery from her third bout of this dread disease.

Usually, the younger the child the more obvious the relationship of the symptom and the purpose for its existence as the following shows:

who came bounding down the stairs half awake. In the ensuing confusion the child continued to cry but forgot about the abdominal pain until the mother asked her about it.

Both parents began to suspect the cause but decided to call the family physician anyway. While the mother was talking on the telephone the little girl's friends, with whom she had walked to school in the past, came by for her. After chatting briefly with the other children and impatiently reassuring her parents that she no longer hurt, she departed happily for school while her parents sat down and tried to comprehend what had occurred.

### *Psychotic Reactions*

#### EARLY INFANTILE AUTISM

In 1943 Kanner described a condition occurring in children, which was assumed to be due either to a severe mental defect or auditory impairment. Such children did very poorly on psychometric testing and responded very little, if at all, to auditory stimulation. But by careful examination it was determined their hearing was intact and that their abilities were more masked than absent.

The most characteristic finding in these children was their inability to relate to other people, from infancy. Their behavior and affective state were seemingly unaffected by others, although they did relate to objects. The majority learned to speak but did not utilize this ability to communicate. It was also noted that the parents of these autistic children were highly intelligent, cold, formal people.

#### CHILDHOOD SCHIZOPHRENIA

The diagnostic criteria in childhood schizophrenia are not clearly established but there is agreement that the older the child the more clearly the symptoms resemble those seen in the adult schizophrenic. This leads to descriptive difficulty since if childhood schizophrenia does not resemble the adult form how is it to be recognized as schizophrenia?

Bender states the symptoms may vary from retardation and withdrawal to intellectual brilliance, with a marked interest in the

abstract. It is further pointed out that all areas of function are involved in the process as opposed to the neurotic disorders of childhood in which a more specific concentration of symptoms occur. Bender believes the etiology to be an encephalopathy occurring at different points of development which interferes with the development of the child's social personality in a characteristic way.

She also stresses the essential role of heredity as a predisposing factor; the illness is said to be precipitated by a physiological crisis but the pattern of the psychosis is determined by environmental and psychological factors. In any event, severely regressed and withdrawn children are seen, who by their eleventh year are negativistic and unresponsive, and who grimace and posture in a manner strikingly similar to adult schizophrenics.

## TREATMENT

### PSYCHOANALYTIC APPROACHES

Kline states that the Oedipus conflict and the formation of the super-ego extend roughly from the middle of the first to the third year of the child's life. Early anxiety is seen as resulting from the pressure of the super-ego on the destructive tendencies during the sadistic pregenital stage. Feared introjected objects are projected, and as external threats to the super-ego produce an even greater impulse to destruction.

"Too powerful" early anxiety and fear of the super-ego may result in the following: an individual may feel compelled to destroy the object or the super-ego may be projected onto objects with a resultant fear and hatred of them. The external world may then become a place of terror and the objects enemies. Such a patient would be in fear of attack "by an enemy within" from whom there is no escape. It is concluded that one of the greatest, if not the greatest, psychological tasks with which the child is faced is the problem of mastering anxiety.

Klein feels that the child's behavior while playing lends itself to interpretation in the same manner that dreams do in the adult. In play, the child expresses phantasies and wishes as well as actual experiences. To understand play correctly "the relation of each



factor to the whole situation" must be appreciated as well as the meaning of separate symbols

Action is considered more primitive than thoughts or words and composes the greater part of play. The observation of the actions in play offers insight into the child's problems. Klein adds that interpretation increases the child's pleasure in playing by rendering unnecessary the expenditure of energy which would otherwise be required for repression.

As an example of how vigorously interpretation may be utilized, the following describes a session with a four year old girl under treatment by Klein. The child became tearful when a sponge was placed near one of her dolls and cried,

"No, she mustn't have the big sponge, that's not for children, that's for grown ups!"

Mrs. Klein told the patient that the 'big sponge' represented her father's penis and 'I showed her in every detail how she envied and hated her mother because the latter incorporated her father's penis during coitus and how she wanted to steal his penis and the children out of her mother's insides and kill her mother."

After this, the child played more calmly.

Anna Freud states that one of the major differences between analysis with children and adults results from the child's super-ego's not having arrived at any real independence. The development of a classical transference situation is prevented by the continuing influence of the original love objects, the parents, on the life of the patient. Treatment of children is educational in the sense of altering the relations with those bringing up the child, creating new impressions and modifying demands.

Freud does not agree with Klein that the child who runs to a lady visitor and opens her handbag is symbolically expressing its curiosity as to whether its mother's womb conceals another little brother or sister "since the behavior might as easily relate to a handbag's having contained a gift on the previous day.

The treatment of the child is complicated by the fact that the child is immature and dependent and therapy is sought by the parents rather than the patient. In addition, both the technique and the therapist are strange to the child. For these reasons, a

period of training during which a relationship of real dependence is developed is required before actual analytical therapy is instigated. The more unlike the ideal adult patient the child is, the longer this training period needs to be.

Freud also stresses the necessity of a positive attachment of the child for the therapist, the need for contact with those charged with bringing up the child, and the greater influence of the 'outer world' on the patient. It is also noted that the child has one set of morals for the grown ups' world and another for himself and his contemporaries.

In treatment, the analyst must succeed in putting himself in the place of the child's ego ideal for the duration of therapy. Dream interpretations apply in the child as in the adult, and in addition the child's daydreams may be of great value in treatment. Unlike adults, the child may produce his daydreams in detail and they may be continued from one session to the next.

#### PLAY THERAPY

Rogerson points out that it is not the interpretation of a difficulty that causes it to vanish but the expression of the difficulty without hostile criticism. Providing the child with materials with which to play (dolls of different sizes, toy guns, cars, paints, papers and pencils, etc.) allows the observer to evaluate the objects and direction of the patient's aggressive impulse.

#### BRIEF PSYCHOTHERAPY

Rogerson's suggestion of noncritical interest rather than aggressive interpretation would certainly seem wise for the physician who lacks extensive experience in this particular field. Allowing the child to explain or interpret his play to the therapist reveals the areas of conflict.\*

An effort should be made to develop a positive relationship with the child by overcoming any anxiety that may relate to the physician. This is not accomplished by an involved explanation

\* It is unfortunate that more therapists cannot be observed in play to determine the direction and degree of their aggressions as well as those of the child.

but by allowing the child to explore the room, ask questions, and encouraging whatever he may wish to discuss while at play

In comparison with other types of medical treatment, psychotherapy requires relatively little activity on the physician's part, instead this procedure demands close observation of the patient and a sustained awareness of his behavior. Too, the child may arrive unwillingly for treatment and his apprehension may be furthered by his parents' concern

The relationship between therapist and child is primarily an affective one, in the beginning, the physician may have to supply the motivation for the treatment to continue. He treats the child as an equal, the patient's opinions are accepted or rejected according to their merit. The physician does not adopt some affectation of speech or unnatural type of behavior at each interview or attempt to be one sort of person with adults and a different (more infantile) one with the patient.

The more quickly the child becomes at ease, spontaneous, and unbothered by the physician's presence, the more rapidly treatment will progress. To establish a relationship in which the patient may more easily describe his difficulties, the therapist should emphasize activities which are interesting to a child of the patient's age and sex.

He should also remember that a number of years and presumably a great deal of experience separate his and the patient's view of the significance of the events described. Sullivan's statement that "the supply of interpretations, like that of advice, greatly exceeds the need" is well recalled. Advice and explanation to patient or parent should be brief, infrequent, and given to accomplish some particular end.

A 10 year-old boy was seen after he had been incontinent of urine and feces on three occasions in school. He had been seen previously by an internist and a neurologist who found no organic cause for his trouble. The mother was a chronically tense individual who periodically received treatment for her persistent headaches. The father did not appear to be interviewed.

The patient was a slender and rather shy boy who verbalized very well about impersonal topics. He was seen on seven occasions. In the

beginning he talked easily of his interests which were primarily sports bicycles, and the car he hoped eventually to own. After the third interview he brought up restrictions which his mother imposed on him. These included not letting him ride his bicycle to school and refusing to let him take a bus to town with his friends when they went to a show. When asked why he thought his mother refused these privileges he replied 'I wish I knew'. On one occasion he added 'I guess she's worried or somethin'.

The mother was advised to allow him the same privileges others in his group enjoyed without emphasizing this as a special favor. This she did readily because there had been no recurrence of his incontinence during the time he was being seen.

At the end of the seventh visit he was asked how he was getting along with his mother. He replied 'She leaves me alone now, I ride my bike and everything'. He was told that if he had any difficulty with which he thought he needed help he was to ask his mother to bring him back. He was agreeable to this suggestion.

His mother was asked to drop a notice to the office every six months as to his progress. This she did for the following two years, and he had no recurrence of the incontinence nor other behavior of concern to his parents.

The interesting aspect of this patient's case was the fact that during his seven hours of treatment he never once mentioned his incontinence. Since he did not mention these episodes and since they had ceased to occur, he was never questioned about them.

### *Procedure in Evaluation*

As complete a picture as possible of the factors acting to produce the child's troubles should be obtained. The parents should be seen individually and together. The area in which the difficulties arise (at home, at school or with some one individual) must be clarified.

A detailed history of the problem, its duration and severity is to be obtained from the parents, the family physician and from the school. If there is question as to the child's intellectual endowment or the presence of an organic process or defect, these possibilities must be quantitated. However, the existence of some minor physical disability should not be seized as the answer to an obviously complex and probably unrelated problem.

After the child has been interviewed on one or more occasions, the parents should be advised of the physician's impression and the treatment plan he believes is indicated. The physician should make an effort not to further increase the parents' concern, and indirectly the child's anxiety, by critical comments regarding their past behavior. It is sufficient if the parents' future attitudes can be altered.

The probable explanations of the disturbance in the child should be consciously considered. As Sullivan states, there should be two or more probabilities considered and as more information is obtained the correct impression should become evident.

# 16

## *MENTAL DEFICIENCY*

Familial Type

Developmental Interference

Prenatal

Paranatal

Postnatal

Clinical Types

Mongolism

Phenylketonuria

The Hydrocephalic

The Microcephalic

Tuberous Sclerosis

Other Clinical Forms

*Clinical Findings*

Management of the Mentally Deficient

## *Mental Deficiency*

The mentally deficient are those having a defect of intelligence sufficient to prevent their competing adequately with their peers or to accomplish an 'independent social adaptation'. This defect may arise from arrested or imperfect development and may vary from a mild to a severe degree.

The present classification restricts the term *mental deficiency* to those cases previously classified as *familial* or *'idiopathic'* and further qualifies the degree of deficiency as *mild*, *moderate*, or *severe*. *Mild* refers to cases showing primarily a vocational impairment (I Q 70-85), *moderate* are those whose deficiency is such that special training and guidance are required (I Q 50-75), and *severe* are those cases whose impairment is so marked as to require institutional or custodial care (I Q below 50).

The evaluation is based on cultural, physical, and emotional adequacy as well as the results of psychological tests. If there are significant psychotic, neurotic, or behavioral deviations, the diagnosis is further qualified by the addition of these terms.

#### FAMILIAL TYPE

The incidence of familial or high grade mental deficiency has shown great variation in past reports (from 90 per cent to 17 per cent). The high grade defective, those having a mild or moderate degree of deficiency, are also termed *moron*, *feeble-minded* or *simple*.



The previous stress on the importance of heredity is well illustrated in the histories of the Jukes and Kallikaks. Estabrook's report in 1915 on the Jukes brought them up to date and disclosed Max Juke (described as a jolly, adequate hunter who was prone to hard drinking but averse to hard labor) had the following among his 2820 descendants: 301 illegitimate progeny, 10 murderers, 366 paupers, and 175 prostitutes, to list only a few of those who had presented a problem to society (the 175 prostitutes were credited with contributing precisely 2655 years of debauchery).

Allen in a recent paper stressed again that such families not only pass on their genes but their cultures as well. Wallin comments that the environmental postulate has been gaining ground during the last century but that heredity is decidedly the most important single causative factor "in the general run of mental deficient."

In 1914 Pearson and Jaederholm showed that intelligence test scores followed a continuous distribution and conformed approximately to a bell-shaped curve. Roberts (1935) found defectives with an I.Q. below 45 were too numerous to fit this random distribution. Therefore, a difference in etiology between the high grade (familial) defective and the low grade defective could be postulated.

Benda states the familial type are biologically normal, with a low I.Q. which is genetically determined in spite of the fact their genes are not pathological. This is in contrast to the low grade defective who represents a "genetic pathological entity" and has a structurally different pattern not comparable to the normal. This group is more abnormal in a fundamental sense but are relatively few in number.

In the familial type of defective quantitative rather than qualitative factors are the central etiological problem, and such patients are subnormal rather than abnormal (Lewis); however, in the low grade the variation may be principally caused by a single abnormal gene (Mayer-Gross *et al.*).

The parents of imbeciles and idiots are nearly always of normal intelligence and the parents of the feeble-minded are generally of dull though not moronic intelligence. A positive correlation has been found to exist between the intelligence of sibs, of married couples, and of "true" children and their parents as opposed to "foster" children.

Benda points out that the marginal group, those testing below 70, are numerically much greater than the expected 2 per cent of the population. He adds that previous studies, as well as clinical observation, show that "low I.Q. ratings and mental defect are not necessarily synonymous." This marginal group may contain emotionally disturbed "normal" children and mentally ill children with adequate intelligence, as well as those with mental defects. The problem of treatment for this marginal group is compounded by the present policy in many child guidance and psychiatric outpatient clinics of excluding patients with an I.Q. of less than 90.

### DEVELOPMENTAL INTERFERENCE

An interference with normal development may occur before birth, at the time of delivery, or postnatally. The interference may be of genetic origin or it may result from an intercurrent injury.

#### *Prenatal*

It is often difficult to determine the nature of the injury that occurred before birth. In addition to inherent factors, virus infections (rubella in particular), toxoplasmosis, the Rh factor, and x-rays may be contributory.

#### *Paranatal*

Any interference producing anoxia of a marked or prolonged degree during delivery may result in mental defect. Traumatic injury with cerebral hemorrhage which may occur in difficult or precipitate deliveries may be followed by mild or severe defects.

#### *Postnatal*

Encephalitis and meningitis are frequent causes of mental defect occurring after delivery. The earlier in life the illness occurs and the greater the severity, the more marked the defect. Trauma to the head, although not nearly so often a factor as the laity believes, accounts for a small percentage of those requiring institutional care.

Following an episode of encephalitis, a previously well-adjusted child may become irritable, destructive, and show a loss of previous

aptitude. He may exhibit temper tantrums or be aggressive and assaultive. The motor restlessness and distractibility may be too disturbing to allow his continuing school.

This restlessness and surplus of energy has been termed "organic drivenness." The general over-activity, which is beyond the patient's control, is attributed to an inner impulsion. These movements which are typically abrupt, explosive, and incessant lack grace or naturalness, even though the patient may attempt to conceal their purposelessness.

It should not be inferred that the behavior of every over-active, restless, or impulsive child is to be attributed to "organic drivenness." The incessant, purposeless movements rather than the distractibility and behavioral disorders are characteristic of this disorder.

A 9 year-old boy was seen in the office. He had presented no problem before his having "influenza" when he was 7½ years of age. He had run a "high" temperature and had been delirious. Following his recovery from the acute illness, he had become such a problem in school that his parents had been asked to remove him.

The degree of his "drivenness" could be judged by the referring physician, who stated the boy had "wrecked" his office while he was attempting to get the history. This included tearing a few pages from a book, running water through his stethoscope, and knocking over two lamps.

The boy arrived for his interview ahead of his mother, slammed the door with such force it could be heard throughout the building, and proceeded immediately to the secretary's typewriter and began pounding the keys, unmindful of the effects on a letter she had been typing or of her protests. While he was being interviewed he would slide completely out of the chair and then climb up over the back. He spotted a small plaster figurine on the desk and immediately grabbed it up and snapped the head off. He was unable to control his restlessness and "drivenness" even momentarily.

These patients are presently classified as chronic brain syndromes with a qualifying phrase to distinguish their particular difficulty.

## CLINICAL TYPES

*Mongolism*

In 1855 Langdon-Down proposed that defectives could be differentiated according to their facial resemblance to the following groups: Mongolian, Ethiopian, Caucasian, and American Indian. The only remnant of this classification in current use is the term "Mongolism."

This particular type of defective superficially resembles those of the Mongolian race. The mongoloid child has a small, rounded skull with anterior and posterior flattening; the palpebral fissure is oblique; epicanthus occurs in 25 per cent of the cases. The child is a "mouth breather," and a chronic nasal infection is a frequent finding. The tongue appears large and usually protrudes. The hands are broad, the fifth finger and thumb are frequently short; and the feet may show a large cleft between the first and second toes. The joints are unusually mobile. Mongoloids appear short, squat, and obese.

The small round head, open mouth, protruding tongue, and short neck are characteristic. Usually, mongoloids are pleasant, curious, and attentive, with bright and happy dispositions. They are the favorites on the ward and receive and enjoy a great deal of attention. The I.Q. ranges from 15 to 50. Beidleman reported an average incidence of 3.4 mongoloids in a thousand births.

Statistically, the likelihood of having a mongoloid child increases with the age of the mother; there is no correlation with the age of the father. Bleyer compared the age distribution of mothers of normal and mongoloid infants and found the peak of maternal age in the normal to be 24 years and of the mongoloid to be 41 years.

Ingalls states that the causative agents of mongolism operate at about the eighth week of fetal life and points out the synchronized relation of the specific arrests which characterize this entity. Such stigma as brachycephaly, maldevelopment of the ear, eye, nose, and palate, as well as the dwarfed middle phalanx of the fifth finger and the septal defects in the heart, are related to injury occurring between the sixth and ninth weeks of development.

The following explanations of the etiology of mongolism have been offered:

1. An altered physiological state in the mother related to her age
2. Maternal ill health
  - a. Hemorrhage and threatened abortion
  - b. Intercurrent infection during pregnancy
  - c. Uterine or placental pathology
3. Conditions (primarily those listed above) causing anoxia or the accumulation of toxic products in fetal circulation.

Such factors as rapid pregnancies and prior periods of sterility also have been suggested; the significance of genetic factors is not yet clarified. The likelihood of having a second mongoloid child is so small that there is no contraindication to further pregnancies.

### *Phenylketonuria (Phenylpyruvic Oligophrenia)*

Following Follings' discovery of a positive ferric chloride test in the urine of defective siblings and his elucidation of the cause as phenylpyruvic acid, Jervis demonstrated that the disorder occurred as a simple recessive inheritance. Folling later showed that this group had a high level of serum phenylalanine, and Jervis found they lacked the enzyme in their livers necessary to metabolize phenylalanine.

Phenylpyruvics account for approximately 0.7 per cent of those in institutes for defectives; the degree of defect is usually extreme. Those with this diagnosis tend to be of fair skin and hair. The contrast in the personality of the phenylketonuric and the mongoloid child is striking. The phenylketonuric is more withdrawn and lacks the happy, responsive behavior seen in the mongoloid. Electroencephalographic abnormalities and convulsive seizures are frequent findings.

Bickel *et al.*, and Armstrong and Tyler have reported the results of feeding a diet either free of phenylalanine or low in this amino acid to phenylketonurics. On such diets a rapid fall of phenylalanine in the blood and of the derivatives in the urine occurred. The convulsive seizures in an 8-month-old boy were controlled after 3 weeks on the restricted diet. The most striking clinical improvement was noted in the youngest subject.

An abnormal indole metabolism has also been reported in these patients with a decreased urinary excretion of 5 hydroxyindolacetic acid, and it has been postulated that a low level of 5 hydroxytryptamine and its impaired synthesis might be a contributing factor in the defective states of these patients

### *The Hydrocephalic*

This disturbance is usually classified as congenital or acquired further division according to whether the hydrocephalus results from abnormalities of production or absorption of the spinal fluid or obstruction to its circulation, have been suggested

Clinically a gradual enlargement of the head occurs the internal pressure causing a thinning of the bones of the skull, a bulging of the fontanelles, and separation of the sutures The face appears small due to the expanse of the forehead Oculomotor palsies nystagmus, and optic neuritis or atrophy may be observed.

### *The Microcephalic*

A defective whose skull does not exceed 19 inches in circumference after growth is complete is considered to be microcephalic Benda lists prenatal developmental anomalies and cystic degeneration of the brain as conspicuous causes A markedly receding forehead and chin, a low hair line, and a flattening of the occiput further characterize this group

## CLINICAL FINDINGS

The retarded child lacks the interest, curiosity, and sustained responsiveness of the normal. He perceives, grasps, and reacts more slowly. His behavior is poorly thought out, and he tends to respond to the most immediate and strongest stimulus (whether it be noise, movement, or music). Habits may be altered with difficulty and abstract ideas are poorly formed. There is a tendency to placidity, to be easily led, and to accept the obvious.

The mentally deficient may be described by a parent as a "good" child who was less trouble and more manageable than the others. He may not show the same degree of possessiveness and attachment to objects (toys, dolls) as the normal. Development proceeds more slowly and ceases earlier than in the normal.

A subnormal child will not be influenced to as marked degree by the behavior of his group as the normal; he is more easily confused, and his confusion and perplexity may lead to teasing, ridicule, anger, and impulsive aggression. On the other hand, these children may be taught what others spontaneously acquire, so that they are not set apart nor avoided because of their behavior or habits.

There may be an evident irregularity of development, with some abilities being more advanced than others. When this occurs to an unusual degree, which rarely happens, one faculty may be outstanding, particularly against the background of general retardation, and the term "idiot savants" has been applied.

Tredgold reports several of such cases and notes they most frequently occur among high grade male defectives. Usually the patient is able to perform some fantastic but circumscribed feats of memory, such as one patient who, when given any date between 1000 A.D. and 2000 A.D., could immediately give the day on which the date fell. Another could multiply four or five digit numbers and give the correct answer in five or six seconds, but was unable to add or subtract. Other patients may also show an unusual sensitivity of touch and be extremely clever in the use of their hands.

Such a patient was seen in the army; how he had managed to progress to basic training without having his limitations appreciated, no

one knew. In any event, his troubles began during the first week when a train happened to pass while his platoon was drilling. Without apparent regard for the commanding officer or the sergeant or their rather plainly stated objections, he departed the ranks on the run to get a better view of the passing train.

He showed no concern for the sergeant's threats of a possible court martial but wept bitterly when they succeeded in returning him to his platoon before the train was out of sight. He was such a likeable individual that the first incident was considered nostalgia; he was given an extra detail, and no more was said. However, within a week a second train watching episode occurred and he was sent to the hospital for evaluation.

He was pleasant, contented, and readily discussed his avid interest in trains and showed no worry over being hospitalized; nor did he see anything peculiar in this rather unusual degree of interest in trains. His history revealed that after some time he had reached the third grade and was then placed in a 'special class'; he had little interest in school and frequently forgot to go, or he would leave the home and become distracted and never arrive.

He was always able to 'fix things' and worked regularly but was only occasionally paid for repairing 'slot machines'. He not only learned how to repair them but was shown how to operate the machines without benefit of coins. He subsequently developed a number of gadgets which were both ingenious and effective, which gained him access to most coin-operated machines. Immediately before his induction in the army he was employed as a bus driver, this lasted for only one trip because he could not follow the route and became lost and the passengers created such an uproar that he stopped the bus and ran off in a panic.

The emotionally stable defective is capable of performing a routine task, he may be confused by unrealistic demands, or be perplexed, frightened, and frustrated by stress. The following case reported by Tredgold illustrates how the defects in intelligence may be overcome by routine in an emotionally stable individual.

"I am acquainted with a feeble minded man John C—, who has steadily and industriously cracked stones by the roadside for the past forty years. He lodges in the village with a labourer and his wife, and



the latter wakes him in the morning, gives him his breakfast, makes his dinner into a parcel, and sends him off to work. When dinner-time comes, which he knows by seeing the labourers in the field leave off work, he eats the contents of his parcel. Sometimes John feels hungry, and eats it before. About five o'clock, which he also knows by the passing of the postman, he leaves off work and returns to his lodging. He has his tea, sits by the fireside until about eight, and then goes to bed. Occasionally John has been known to get tired of work and come home in the middle of the afternoon; but such lapses are very rare and on the whole he is exceedingly methodical and industrious. He knows that Sunday is a day of rest, but he must be told that it is Sunday, or he would go to work as usual. John's landlord once played him the prank of not telling him it was the Sabbath, and he went off as usual without any suspicion. But he had intelligence enough to notice the trick on passing through the village by seeing that the shop was closed, and he came back vastly amused at what he thought was a fine mistake. He receives a few shillings each week from the Rural District Council, and this he faithfully carries to his landlady, who allows him a penny now and then when he asks for it. This, however, appears to be seldom, for John seems to be in the happy condition of having all his wants supplied."

The crimes committed by the unstable defective are characterized by their impulsive and usually pointless nature. Arson, crimes of violence including sexual assault, particularly on children, and exhibitionistic behavior by the male are reported. Such patients are easily persuaded and used by able-bodied sociopaths for their own ends. Various studies report approximately 10 per cent of criminals are mentally defective, the incidence being much higher among recidivists.

A 24-year-old defective was arrested following his apprehension while standing on a box peering in a kitchen window. When asked what provoked this activity, he replied he had seen the light from the street and wanted to look in. When he had looked in the window no one was in the kitchen so he had just stayed there, standing on a box outside the window waiting for someone to come in, until he was apprehended.

A 19-year-old girl was arrested for vagrancy after it became apparent she was literally living in the waiting room of a large railroad terminal.

While in jail she repeated meaningless phrases or ignored the questions asked her and an evaluation was requested.

When first admitted she appeared perplexed and inappropriate when interviewed she smiled and mumbled to herself. The following day she was more responsive and when taken to occupational therapy she showed an immediate interest in drawing and painting. She was well known to the social service department. Her mother had been committed as being mentally defective with a psychotic reaction after an elopement the mother was returned pregnant and the patient was delivered in the hospital.

Repeated attempts to place her in foster homes had met with failure. She worked spasmodically would steal whatever caught her eye and would suddenly disappear from the foster home. She was an attractive bright eyed well-developed girl who could write her name with difficulty but little else. Her behavior varied on occasion she followed the ward routine with a childlike obedience at other times she was irritable peevish and clever in avoiding what she didn't want to do. With the male members of the staff she was quite the coquette with much winking as she regularly repeated one remark. All that meat and no potatoes.

She was later followed sporadically as an outpatient and would appear at all hours of the day or night on a weekend or apparently whenever the idea happened to occur while she was in the area of the city where the hospital was located. It disturbed her momentarily if she could not see the interviewer but this disappointment was very brief and a new doctor was just as well if one was available.

### MANAGEMENT OF THE MENTALLY DEFICIENT

Too frequently a loss of therapeutic interest accompanies a report of an IQ under 80 or 90 in spite of the fact that the patient may be capable of making a very satisfactory emotional adjustment.

A stable individual who has only a mild or moderate degree of deficiency may be taught in special classes and be able to follow a routine existence in the same manner as the normal. Those with a severe defect (the imbeciles and idiots) require physical care protection and supervision which is usually more adequately accomplished in an institution.

The decision as to whether a defective child should be kept in

the home or placed in an institution should depend on the particular circumstances involved. The degree of defect, the physical care and supervision required, the parents' attitude, their age, health, and ability must be considered. The parents, and particularly the mother, should be allowed to express her feelings about the management and disposition of the child. The diagnosis should be stated with certainty, and the expected course over a period of years should be clarified.

The effects of a severely defective child's presence on the other children, and the family as a whole, should be weighed. The decision should depend on what will be gained or lost by the child and the family from home or institutional care in the years that follow.

The occasional story in the lay press of a patient's spending years in a home for defectives until it is discovered he does not have an intellectual defect may fail to clarify that this is the rare exception. Such stories may create worry and guilt in the minds of parents of other patients. These incidents only stress the need for more careful evaluation of defective patients.

Perhaps one of the greatest needs of such institutions is adequate funds to hire a professional staff and to maintain a program of training and rehabilitation. Without adequate help from social service, those trained and those able may not have the opportunity to return to the community.

Sterilization is another decision to be arrived at individually, since it solves those problems which result from the patient's fertility, but it has hardly offered a solution to the problem of mental deficiency. On the other hand, there is no evidence to show that pregnancy is beneficial to a defective girl, but there is no shortage of evidence that her child may be neglected and cruelly treated.

*EPILEPSY***Types**

Grand Mal Epilepsy  
Typical Grand Mal Seizure  
Seizure Patterns

Petit Mal Epilepsy  
Psychomotor Epilepsy

**Etiological Factors**

Age  
Heredity  
Other Factors

**Electroencephalography****Treatment**

Anticonvulsant Drugs  
Status Epilepticus

## *Epilepsy*

Epilepsy is an intermittent disturbance of brain function which tends to recur, the character of the episode being determined by the site of the disturbance and the extent and method of the spread of the intense discharge. As more understanding of this disorder is obtained, it is regarded more as a symptom complex than a disease entity.

## TYPES

### *Grand Mal (or Major) Epilepsy*

Approximately 50 per cent of patients having grand mal seizures experience an aura or warning of an impending attack. The aura accompanies the onset of the discharge and, depending on the site of the focus, the patient may be aware of motor or sensory phenomena.

The aura may be vertigo, a sinking sensation in the epigastrium, a twitching of a muscle group, or numbness and tingling in an extremity. The warning or aura may be experienced alone without a grand mal seizure occurring and the patient may attempt certain maneuvers in an effort to avoid the attack.

Behavioral changes precede an attack by hours, or a day, or longer in some patients. These changes vary from increased irritability and depression, to euphoria. Precipitating factors are usually not found, but situations which may provoke syncope may also provoke a seizure.

## TYPICAL GRAND MAL SEIZURE

Consciousness is lost suddenly and the patient falls; injuries may occur as a direct result of the force of the fall or due to the patient's falling against an object that injures him (such as a radiator or a stove.) The first motor manifestation is usually a generalized tonic contracture; as the air in the lungs is forcibly expired a scream or "epileptic cry" may be heard. The tonic phase usually lasts only a few seconds and is followed by the clonic phase in which a series of muscular jerks of slowly decreasing severity occur.

As the seizure continues the patient becomes increasingly cyanotic until respiration resumes during the clonic phase. Fractures or dislocations (acromioclavicular separation is a frequent site) may occur during the clonic phase, particularly in the muscular male; the tongue may be bitten and the collected saliva may be blood tinged.

The pupils are usually fixed and dilated; urinary and fecal incontinence may occur. After the muscular jerking ceases unconsciousness persists from minutes to half an hour. The patient appears groggy and confused, and responds poorly; he has a headache and typically sleeps for an hour or longer but usually wakes with a clear sensorium, and has no memory of the episode. The following day he may be somewhat lethargic and complain of a generalized muscular soreness.

## SEIZURE PATTERNS

In addition to the usual grand mal seizure with immediate loss of consciousness the following also occur: Jacksonian epilepsy, in which the seizure begins with clonic movements in one area (the thumb and index finger, the angle of the mouth, or the great toes most frequently) and then becomes general; and adverse attacks which begin with a turning of the head and eyes.

*Petit Mal (or Minor) Epilepsy*

Petit mal epilepsy is characterized by disturbances of consciousness lasting a few seconds, in which motor phenomena are absent or lack prominence. The electroencephalographic tracing shows a

characteristic 3 per second wave and spike pattern Clinically, the patient ceases what he is doing briefly and then continues as before He may stare fixedly and not respond or he may drop what is being held, minor muscular twittings may also occur The patient may be aware of a blank in his awareness The onset is usually between four and eight years, as a rule, by 18 years of age the attacks cease or they are replaced by other types

In akinetic or 'drop' seizures the patient suddenly falls to the ground with a momentary loss of consciousness In myoclonic seizures\* sudden twitches or violent contractions of a part or all of the body occur Lennox groups the momentary absences of consciousness, the akinetic seizures and myoclonic seizures together as the *petit mal triad* These three varieties all show wave and spike activity in electroencephalographic tracings and a similar sensitivity to changes in acid base balance

### *Psychomotor Epilepsy*

Characteristically, psychomotor seizures produce a disturbance of consciousness (rather than a loss of consciousness), and automatic behavior with little or no incidence of convulsive phenomena The patient may appear confused, bewildered, or delirious during these periods of disturbance of consciousness aggressive impulsive, purposeless acts may occur for which the patient has no memory The confusion usually persists for seconds or minutes but in rare cases may be prolonged for hours

Psychomotor epilepsy is more frequent in adults than children and its frequency tends to increase with age Deja Vu phenomena in which the experience or surroundings seem vaguely familiar may occur, or the patient may merely feel peculiar During an episode the patient may only pass his hand before his face make smacking movements with his tongue and attempt to swallow others may wander aimlessly about without responding to com-

\* Brain reserves the term "myoclonus epilepsy" for the rare syndrome first described by Unverricht in 1891 This type is usually familial the onset is in childhood or adolescence typically with nocturnal grand mal seizures after several years the myoclonic twittings appear and a progressive dementia develops Intracytoplasmic inclusion bodies within nerve cells are demonstrable without evidence of inflammatory disease.



mands, whereas a few patients show violent or brutal behavior for which they later have an amnesia

The characteristic interseizure electroencephalogram shows spike seizure discharges arising from the anterior temporal lobes (these may be more easily detected in a sleep record) The predominance of psychological symptoms during an attack has led, in the past, to such terms as "psychic epilepsy" and "epileptic equivalents" to explain these psychomotor seizures Presently, psychomotor seizure states are increasingly referred to as *temporal lobe epilepsy*

A 22 year-old college student was referred because no basis for his unusual sensations could be found He was tense and self-conscious and it was difficult for him to talk with strangers, these problems had been aggravated by his beginning college

He stated that for the past several weeks, he had 'spells' when he did not feel "right", his physician had never observed him during an episode, but others had and noticed nothing unusual in his behavior The neurological examination was not unusual and an electroencephalographic tracing was reported to be within normal limits

During the second interview he was questioned regarding his relationship with girls, instead of answering, he flushed, passed his hand over his face, swallowed, and smacked his lips This behavior lasted less than 30 seconds 'I just had a spell,' he said. The etiology was not suspected because of the similarity of his response to that previously seen when a question was asked which caused him embarrassment. The interviewer's awareness was also dulled by the normal electroencephalographic report and a lack of positive findings in the neurological examination.

He was placed on Mebaral for his tension and was followed at 11 regular intervals as an outpatient, his 'spells' became infrequent and his tension less marked Four months later he had a grand mal seizure and a second electroencephalogram showed a typical spike seizure discharge in the left temporal area Surgery was carried out and an expanding lesion involving the left temporal lobe was found

### ETIOLOGICAL FACTORS

Seizures may accompany systemic disorders as well as trauma, tumors, infection, degeneration, or toxic processes affecting the brain primarily Epilepsy reportedly develops in 45 per cent of the

cases in which cerebral trauma is accompanied by penetration of the dura. A large group of epileptics are classified as idiopathic because no demonstrable cause for their illness has as yet been found; with increased understanding, those in this group should be reduced.

### *Age*

The onset is before the age of 20 in three-fourths of all cases of epilepsy. Brain describes the frequency of onset as being high before age three. Other ages during which seizures are likely to begin are during the seventh and again between the fourteenth and seventeenth years of life. The incidence is approximately 5 per 1000.

### *Heredity*

Lennox, Gibbs and Gibbs state that abnormal electroencephalograms are six times as frequent among the relatives of epileptics as among controls. The physical basis for a cortical dysrhythmia is inherited but only a few of those with such an inheritance become epileptic.

### *Other Factors*

Migraine has been associated with epilepsy by some observers and rejected by others. The relationship between menstruation and the precipitation of attacks in females is unexplained.

The differentiation of psychomotor epilepsy and dissociative reactions should not be difficult unless the epileptic patient also demonstrates hysterical behavior. The patient with grand mal seizures who also has gross hysterical features may be most perplexing, as the following case illustrates.

A 26-year-old married female gives the following history: during her first pregnancy at 19 she began to have typical grand mal seizures which continued after her delivery. While alone in her home she had an attack and fell against the stove, suffering a third degree burn to her right thigh. In spite of this experience and other injuries during seizures, she took her anticonvulsant medicine "when she felt like it" because she knew she was not epileptic.

She had been hospitalized after she suddenly developed an aphonia

from which she as suddenly recovered. On another occasion while alone at home she was approached sexually by a male acquaintance who had been 'bothering' her for some time. She had a seizure which failed to dissuade her acquaintance, she stated she was aware of his fondling her sexually but was unable to resist or move until she finally 'woke up'. The patient visited several physicians, who were about equally divided in their impressions as to the etiology of her troubles. Their decisions would depend on whether she was seen following an epileptic seizure or after a histrionic demonstration in an emergency room.

### ELECTROENCEPHALOGRAPHY

In 1929 Berger successfully recorded changes in electrical potential in the brain through the intact skull. It was later established that these electrical impulses occur at a rate of approximately 10 per second in the normal resting adult. The electroencephalographic tracing is studied to determine the amplitude and frequency of the waves and the area of the brain in which abnormal impulses may arise.

In between 80 and 85 per cent of all epileptics, dysrhythmias characteristic of this disorder are demonstrable, similar abnormalities are found in 5 to 10 per cent of the electroencephalograms in normal individuals.

A routine electroencephalograph is of great diagnostic value in 48 per cent of those patients with a history of seizures, in 42 per cent it is of little or no value. In addition, electroencephalograms are of benefit in the diagnosis of tumors or abscesses involving the brain above the tentorium and in subdural hematoma, cerebrovascular disease, and brain injury.

### TREATMENT

#### *Anticonvulsant Drugs*

The improvement in the symptomatic control of epilepsy during the past two decades has resulted in the abolition of grand mal seizures in 75 to 80 per cent of the patients treated and justifies calling this the 'hopeful disorder'. Some patients respond better to one drug than another, or better still to a combination of medications rather than to each given individually.

Physicians frequently have preferences for a particular anticonvulsant medication, however, this preference should not lead one to change or discontinue the medication in a patient whose seizures are controlled, who has no side effects, and who is quite content with the routine being followed.

This is illustrated by the remarks of a patient the first time he was seen

' Doctor, I hope you aren't going to change my medicine. He was asked when he last had a seizure and how he had been getting along. The patient replied, I haven't had a seizure in over two years and I feel fine. The last time I had a seizure was a little over two years ago I moved and the new doctor said I didn't need Dilantin and Mebaral both and stopped the Mebaral. Then they like to never got me straightened out again.

When medications are changed the new one being introduced should be gradually increased to the optimum level and then the previously given preparation should be gradually decreased. Phenobarbital, in particular, should not be abruptly discontinued.

Side effects such as lethargy, drowsiness or mental dullness should be checked. During the first month or six weeks on a new preparation the patient should be seen weekly to determine his response and the presence of side effects. A blood count and urinalysis should be obtained at the time of the visit.

Grand mal seizures and psychomotor seizures are presently best controlled with either the barbiturates or hydantoins or a combination of the two. The barbiturates most tested and used are phenobarbital in a daily dose of from 0.1 to 0.3 gm and Mebaral in a daily dose of between 0.2 and 0.6 gm.

The most widely used hydantoins are Dilantin (diphenylhydantoin sodium) in a daily dose of 0.2 to 0.6 gm and Mesantoin the daily intake being between 0.2 and 0.8 gm. When a combination of Dilantin and phenobarbital are used the therapeutic dose of each should be given.

In petit mal attacks (the petit mal triad) either Tridione or Paraldehyde are effective in a daily dosage of 0.6 to 3.0 gm.

Aside from any physical injury that may occur coincident with the seizure perhaps the most harmful aspect of a major attack is

the effect on the patient's standing with his associates. The sudden outcry, the violent movements, and the cyanosis which accompany a grand mal seizure are perhaps the most disturbing nonfatal events one human can observe in another. The patient has no memory of the episode, but unfortunately the observers do.

The physician, in addition to prescribing anticonvulsants, must acquaint himself with the other problems this illness may present. If the patient has complaints about a remark a neighbor or another employee made about epileptics, his complaint should be heard before reassurance is given. If the patient desires it, the employer should be reassured and informed of the nature of the illness and the adequacy of available treatment.

The questions, fears, and apprehensions of the parents of a child who has seizures should certainly be heard in detail. The physician's answers should be brief and should fit the patient being considered. The questions asked by patients or parents are not motivated by an interest in brain physiology, but by concern over their own or their child's future.

### *Status Epilepticus*

A succession of seizures which is not interrupted by an interval of consciousness is termed status epilepticus. This is always a serious complication and the patient should be hospitalized. Sodium amytal given slowly, intravenously in a dosage of 0.5 to 1.0 gm. has been recommended. Sleep may be maintained by an intravenous drip of 0.5 gm. of sodium amytal in 500 cc. of isotonic saline. Dilantin is available for intravenous or intramuscular use, and the amount given should not exceed 500 mg.

Paraldehyde is also effective and is preferably administered by suppository, or it may be given in 5-cc. doses intramuscularly. The withdrawal of cerebrospinal fluid and hypertonic solutions of glucose or sucrose intravenously have been recommended. The patient should be turned at 30-minute intervals, the foot of the bed should be elevated slightly, and a suction apparatus should be available to assure the patient of an adequate airway.

# *EMOTIONAL PROBLEMS IN THE GERIATRIC PATIENT*

The Process of Aging

Anxiety

Sources of Anxiety in the Aged

Altered Concept of Self and Threats to Individual's Physical Existence

Loss of Status

Lack of Motivation

Psychotherapy with the Older Patient

Psychotic States

Depression

Manic Depressive Reaction

Psychotic Depressive Reaction

Paranoid States

Delirious States

Evaluation of Organic Deterioration in the Aged

Procedure in Evaluation

History from Relative

Determining the Clarity of the Patients' Sensorium

Orientation

Memory

Labile and Shallow Affect

Improvement of Judgement and Intellectual Functions

Chronic Brain Syndromes

*Emotional Problems  
in the Geriatric Patient*

Senile Brain Disease  
Cerebral Arteriosclerosis

Changing Attitudes of the Community and the Family  
toward the aged

Housing for the Aged  
Recommendations to the Family

'It is sufficiently obvious that life, like any other process, has a beginning and an end, and that every beginning is also the beginning of the end —JUNG

Aging hardly requires definition since it is so obvious in one's friends, as they lose hair, teeth, or life itself. More appropriately it might be asked, 'When is a man old?' Perhaps when he leaves a convention feeling better than when he arrived. In any event, age is not strictly chronological, a man's years are not necessarily a true measure of his loss of function. It seems most likely that as an increasing percentage of the population reach an advanced age, the particular year when a man is considered old or is expected or forced to retire, will be advanced. For instance, in July 1844, Dr Amariah Brigham wrote a physician friend as follows, 'I am getting old and averse to labor and cannot, I think, take charge of the Journal of Insanity another year.' He was 48 at the time.

Since, in 1958, anyone 60 years of age had a life expectancy of 16 1/2 years, it would seem likely that the age of retirement will eventually have to be extended, probably to age 70. Further improvements in the treatment of malignancy and heart disease should produce an immediate increase in the life expectancy of this age group.

When a large number of a population live longer, merely being old ceases to be an accomplishment or a reason for respect from the younger, at the same time a need is created for the aging to be productive for a longer period. Perhaps in no group of patients are emotional difficulties more causative of the physical complaints for which medical help is sought than in the geriatric patient—the



increased physical awareness of self which age brings, and a reduction of other interests gives discomfort a new and threatening meaning.

The number of extra days one might expect to survive if his life were free of alcohol, cigaret smoke, and animal fat has not been precisely calculated; the number would probably be greater for those wise enough to select long-lived ancestors.

Although there are no psychoneurotic reactions unique to the aged, they do present particular problems in treatment. Freud pointed out that his method was not suited to the elderly because of the time and motivation required for psychoanalysis.

Jung counted many of his therapeutic failures among his older patients and contrasted their problems with those of the younger. The life of the younger was said to be marked by "an unfolding and striving toward concrete ends," and if a neurosis developed it resulted from a hesitation or shrinking back from this necessity.

The life of the elderly, on the other hand, is marked by a "contraction of forces, by the affirmation of what has been achieved." Attempts to cling to youthful attitudes no longer in season and the shrinking back from the prospect of death, Jung held, were typical of the aged neurotic. It seems likely that the "aged neurotic" has been a younger neurotic, who appears for treatment only with the added pressure which senescence may bring.

It must be added that our culture does not emphasize age as a particularly desirable state; the emphasis is rather on "not getting old" or at least not acting "old."

### THE PROCESS OF AGING

It must be presumed that aging begins when growth ceases and is accompanied by a declining vitality or biological efficiency. Bidder pointed out that size and function rather than senescence accounted for a cessation of growth, and that senescence may in turn result from the continuing action of metabolic regulators after growth is completed.

Medawar regards senescence as a change of innate origin which would occur even under the most favorable conditions, and is in essence a measure of vulnerability or the likelihood of dying as

life continues. Comfort points out how a cumulative failure of homeostasis could affect the body as a whole and terminate in a loss of coordination or falling apart of the various processes necessary to maintain a physiological balance.

Cameron doubts the existence of specific structural disturbances due to old age but feels rather that aging is the vector sum of all morbid processes existing in the individual. He concludes that the remedy for aging must needs be sought in youth and holds with Montaigne that death is but an end to dying. Meda war points out that most pathologists do not hold with the concept of natural death but rather with the idea that everyone dies of something. Theoretically at an extreme age the lethal threshold could fall to a level where a very minor disturbance would be come mortal. (As one aged patient remarked, "I sneeze with care.") This is substantiated by autopsies on very aged patients who were apparently in good health until shortly before their death; these postmortem examinations revealed several morbid processes any of which could have resulted in the individual's demise.

Metabolically during the anabolic stage of growth the tissue mass increases. This is followed at maturity by a period of stability when the tissue mass is relatively constant. During the third or catabolic phase the tissue mass declines. This last phase in the elderly is accompanied by increased ease of fatigability, a loss of strength and a loss of muscle mass.

Attempts to prevent, halt or reverse the process of aging *per se* have been made in all cultures since man's unfortunate discovery that he as well as his contemporaries was undergoing an undesirable change with time. The life expectancy has increased markedly for the younger in this country but the increase for the very elderly is much more modest. For instance the life expectancy of a man who was 80 last year was only a year and a half more than for a man of the same age in 1868.

The innate biological changes apparently continue as they ever have but illness and injury which in the past may have compounded man's infirmity have been altered. The sum of the morbid processes in the elderly is less as pneumonia, fractured femurs, and diabetes (to name a few) are more adequately managed. This

decrease in morbidity in the earlier years should also decrease in some degree the disability later in life.

## ANXIETY

The anxiety which conflicts between unacceptable impulse and intolerant superego produce should abate with age; since there is general agreement that the sexual drives wane with time and that one's appetites do change, repression for the aged should be less a problem. Therefore, unconscious threats to the ego would seem less important than those hazards posed by reality with an increasing infirmity and possibility of death.

### *Sources of Anxiety in the Aged*

#### AN ALTERED CONCEPT OF SELF AND THREATS TO AN INDIVIDUAL'S PHYSICAL EXISTENCE

The inner concept a person holds of himself is not clear-cut and probably not consciously considered except in moments of guilt. The changes this concept undergoes during the different stages of life are even more vague; but it is this concept of self which eventually must accept the restrictions and altered goals of senescence.

This appraisal of self is probably altered by decades rather than by years. In other words, one's behavior is usually appropriate to the decade of his life. There are ways to act in your "twenties," in your "thirties," and society even makes allowance for the "foolish forties" for the male (even though the wife may not).

The longer any individual exists the fewer of his contemporaries will survive. The mortal illness of a friend produces a depression of mood in the survivor; but in addition, the closer the friend was in age, background, and previous activity to the survivor, the more obvious is the possibility that he might suffer a similar fate. The death of a peer is unusual in the young but it happens with increasing frequency to the older individual.

Any normal person is affected directly by what happens to his contemporaries and if one or two of his associates suffer coronary occlusions or cerebrovascular accidents, he will usually become somewhat more aware of his own cardiac status or any discomfort involving his head.

It has been pointed out that most of our training and education is for the first half of life and the patient according to his particular faith individually seeks or fails to find his own answers to the problems which arise during the latter half. As more and more people who reach 50 are faced with 20 or more years of life this problem of meeting the later years may assume greater importance.

This has not been viewed as a medical problem and the patient is routinely approached as though physical immortality were just around the corner the physician's responsibility being to preserve life and not to prepare the patient for death. However fears of death may provoke many of the complaints in the aged for which no other adequate basis can be discovered. This does not imply that the aged patient should be given a briefing on the fact that physical death is here to stay, since this is one of those subjects which allows scientific discussion only by those not immediately faced with the prospect of dying.

Rather it is suggested that the physician is one of the few people whom the patient may meet with whom he can discuss his fears. Members of the family naturally do not like to consider the prospect of his death and attempt to distract and reassure the patient without hearing him out whenever he brings up the subject.

The physician can hardly have a set of answers to prepare one to meet his Maker, but by being interested and undisturbed he may aid the patient in accepting the inevitable and he may at the same time determine the degree of depression from which the patient may be suffering.

The elderly have less opportunity less vigor and less motivation to continue to make new acquaintances and to develop new interests. The elderly frequently feel rejected unwanted and lacking in purpose. As they are less able physically and less active socially their self-confidence and feelings of security may suffer. Many fear they will be removed from the family and the community that they will be sent away—and many are.

#### LOSS OF STATUS

After spending 65 years in a society which stresses success in competition some find the prospect of being permanently unemployed somewhat less than stimulating. An individual's employ-

ment, in addition to providing a salary, gives him purpose and the satisfaction of being important to others. The respect for seniority and ability which long-continued service provides are sources of strength to the ego; these satisfactions may be lost and sorely missed following retirement.

An abrupt termination of responsibility, in which the longtime employee receives a wristwatch with his years of service engraved on the back, and the reassurance that "things will never be the same" without him, slams the door on his whole pattern of living. The family is seldom impressed for long with the retired individual. After he is around home for a few weeks he may find the respect he commanded in his office lacking, and he may be more irritated than pleased with the menial household duties the family feels he should assume. Not much happens to him, minutiae are exaggerated, his aches and pains and the day's routines increase in importance; his relatives soon begin to hear more and more about the "good old days."

Inactivity, leisure, and freedom from responsibility are passions rather quickly satiated in those accustomed to activity; and, as has been pointed out, a man can hardly desire more of what he already has in excess. Retirement is a particular problem for those who have had few outside interests and few friends; if their job has been their only source of pleasure and prestige, the loss may be overwhelming.

Within a few months a retired individual may be regarded more with tolerance than pleasure by the family. This may provoke hostility which the family regards as further evidence of aging; and they may become almost professional in their understanding. This is indeed irritating; and the elderly male, still in possession of his faculties and humored by relatives younger but less able, may either become openly angry or he may withdraw and become anxious and hypochondrical.

#### LACK OF MOTIVATION

Whether young or old, an individual is motivated to maintain the concept he holds of himself. The validity of this concept in the aged should have been confirmed and enjoyed in previous accom-

plishments and be modified to accept the restrictions of aging and his eventual demise. If the older person no longer feels there is a purpose for his existence and concludes he is neither needed nor wanted, he may become anxious, agitated and depressed.

### PSYCHOTHERAPY WITH THE OLDER PATIENT

If simple reassurance as a form of psychotherapy were as simple as the name implies, it could be given at home by the family which would spare the elderly patient the discomfort and expense of a trip to the physician's office. But unless the patient's problems are clarified, the reassurance may be offered on fears the patient is only presumed to have, or what is worse, he may be given troubles not to worry about that he did not know he should worry about in the first place.

Examination should precede reassurance regarding a patient's physical state, because unless the individual has undergone a rather severe degree of deterioration, he will be aware that advice offered without an examination may have a slight philosophical value but nothing else. The soundest reassurance a physician can offer is a thorough physical examination.

It should also be recalled that the older patient frequently comes to the office to be heard and not to listen. Questions which the patient asks should be answered *always* with an eye on the reason for the asking. An elderly patient inquires about a stroke not because he wants to listen to a scientific discourse, but because he wants to be assured he is not likely to experience one. The answer to such a question should first elucidate why it was asked and the answer should fit the patient's need rather than medical facts.

If the physician could predict precisely when the patient might suffer a cerebral vascular accident or when he might expire, and if there was a reason to do so, then the physician might have occasion to so inform the patient. This degree of clinical exactness has not yet been routinely demonstrated, and until more certainty is possible, relieving the patient's concern should be the first objective.

Areas of conflict in the present may be tactfully sought, any hostility expressed should be listened to without interrupting to

offer advice. Most important, the doctor should be interested and aware; the interview should be pleasant and not disturbing; and the patient should feel better when he leaves than when he arrived.

## PSYCHOTIC STATES

### *Depression*

#### MANIC-DEPRESSIVE REACTION, DEPRESSED TYPE

With an increasing number of patients reaching an older age, there is a greater likelihood of the longer-lived cyclothymic individual's having another episode late in life. This may be either of a depressed or manic type; and the retardation which may accompany the depressions must not be attributed to aging and left untreated.

#### PSYCHOTIC-DEPRESSIVE REACTIONS

These may arise chiefly from two precipitating sources:

The loss of another person, usually the spouse, on whom the patient has become excessively dependent. Not infrequently following the death of one member of an aged couple, the survivor shows little interest in living, lacks vigor, and may quickly become debilitated and succumb.

Perhaps seen even more frequently is the individual who "lives for his work"; following retirement he loses his appetite, develops insomnia, shows retardation or agitation, and within a few months commits suicide or is hospitalized.

The diagnosis of depression in the aged is made difficult by the fact that 10 per cent or more of those with cerebral arteriosclerosis may show depressive symptoms in the beginning; too, an organic deficit may be evident in those who are primarily depressed. Any of the following may be helpful in differentiating the depressed individual from the organic: the relation of the symptoms to some misfortune that has beset the patient; a rapid loss of energy; and the development of an apathetic state without neurological evidence or a history of apoplectic phenomena.

In the older patient, the physical results of the depression pose a particular hazard. An inadequate intake of food, insomnia, and agitation may very rapidly debilitate an older individual. In such

an instance the physician cannot compromise the patient requires immediate hospitalization and treatment

### *Paranoid States*

Suspicious and delusions may accompany the development of confusion in the organic states. As an example an arteriosclerotic individual was sent in for observation after he was apprehended looking in a window, he blamed his arrest on a group in his town who were 'out to put him away', he then added 'I was not at any window and I didn't look in and anyway, there wasn't enough light for them to see me'.

The development of paranoid states in elderly patients in whom the sensorium is relatively clear is not rare. About a fourth of these people have serious defects of sight or hearing which may add to their tendency to delusional misinterpretation.

At the onset there is a further withdrawal complaints to the police about some neighbor's interference, endless checking on the spouse, hours spent at the window watching signs made toward the home by strangers. The delusions may be centered about some one individual, for instance, a younger woman moves in next door and makes suggestive remarks or sexually invites the patient's aged husband. The accusation may perplex and annoy the spouse not infrequently he will visit the lady in question and persuade her to talk with his wife. This denial only confirms the patient's earlier suspicions.

### *Delirious States*

These are states of clouding of consciousness which may be precipitated by a systemic illness or head injury or following surgery (particularly prostatectomy or excision of a cataract). The older patient who has a history of a brief period of disorientation after taking an afternoon nap may give forewarning of a proneness to transitory delirious states. Such patients may be somewhat perplexed and a little concerned because they slept briefly in the afternoon and then proceeded to prepare breakfast another may be found preparing a meal in the middle of the night unmindful of the time.

At the onset of a more delirious state the patient may merely



seem suspicious of the medicine being given or inattentive and unable to concentrate. This may soon be followed by a restless, purposeless over-activity and irritability. The classical picking at objects or self, fingering the covers, climbing out of bed, misidentifying people, with an incoherent and rambling speech, may follow. The symptoms seem more marked at night, or in any event they are more disturbing to others at night.

Recovery from the episode occurs in about 50 per cent of the cases and is not routinely the beginning of a chronic deteriorated state. In others, the acute phase is followed by a persisting disorientation or deluded paranoid condition.

Treatment is primarily medical; in 1942 Robinson reported a marked decrease in mortality in such patients when glucose in saline was substituted for the previously recommended 50 cc. of 50 per cent glucose. The aged seemingly tolerate the phenothiazine derivatives rather well, and these preparations are indicated for control of their restlessness.

### EVALUATION OF ORGANIC DETERIORATION IN THE AGED

Misleading factors which may conceal the extent of deterioration an aged patient has experienced include his being clean shaven and well groomed. This may result from the family's efforts to prepare him for a visit to the physician.

A second and more important factor is the tendency shown by the aged to avoid or evade questions which may reveal their lack of orientation. For instance, when asked the date the patient may reply, "I didn't see the morning paper," or if asked how he has been spending his time he may reply, "Oh, just doing the usual things." Even markedly deteriorated patients may laugh at the question as though it were too silly to bother answering. Another frequent means of avoiding an unanswerable question is to refer the answer to someone else in the room, particularly a relative; if there is no one else in the room the patient may reply, "Oh, you know that."

The patient's appearance, his general attitude, and his replies to nonspecific questions are not a valid basis for evaluating the mental status of an aged individual.

## *Procedure in Evaluation*

### HISTORY FROM RELATIVE

A responsible relative, one who has been in contact with the patient, should be questioned about the patient's recent behavior. Such episodes as becoming lost in the house or in the neighborhood and of waking confused should be noted. Of particular concern is a tendency for the patient to wander away from home, to ignore passing cars, to cross busy streets without concern or caution, and to attempt to start a fire and forget to light the gas after it has been turned on.

Too, an increasing shallowness of affect in the patient should be checked with the relative. Such occurrences as the older individual's becoming tearful without apparent cause while talking to another, or weeping while reading the comics, or being unduly affected by radio or television programs should be noted if in contrast to their earlier behavior.

### DETERMINING THE CLARITY OF THE PATIENT'S SENSORIUM

The patient should be advised he will be asked some routine questions and the following should be determined:

*Orientation* The patient should be asked the date, the place and the identity of the examiner. These questions may be approached subtly, but if the patient is evasive or irritated they should be directly stated.

*Memory* The patient should be asked about his recent activities and his answers must be checked with a member of the family. The remote memory will be more intact than the recent, and early rote learning better retained than recently acquired facts.

*Labile and shallow affect* The patient should be asked if he feels sad or depressed, and should be observed to determine if the mere asking of the questions appears to produce a change in mood.

### IMPAIRMENT OF JUDGMENT AND INTELLECTUAL FUNCTIONS

Impairment of judgment varies from a subtle loss of acumen in a previously astute individual to a state of confusion with a total lack of awareness or insight. Problems arise when the patient's failing judgment jeopardizes his security or his life's savings.

In any event, the patient should be observed closely and repeatedly (unless the deterioration is obvious and easily demonstrated) before he is pronounced unfit to manage his own affairs, another physician should concur in these conclusions before the individual is judged incompetent and the appointment of a guardian is recommended.

In intellectual functions, the patient's past level of achievement should be taken as a basis for estimating his fund of general and specific information.

## CHRONIC BRAIN SYNDROMES

### *Senile Brain Disease*

This usually begins later in life, after 65, and follows a more gradual course, with less insight and less concern than in those with cerebral arteriosclerosis. The interests are narrowed, the powers of concentration and comprehension decrease, ritual and routine are preferred, and change is avoided. (As an example, on a ward of 10 senile patients, who superficially gave no appearance of their markedly demented state, the morning paper remained unopened on the table and the television picture flipped over and over without those seemingly interested noticing or making any attempt to adjust it.)

The course is usually slowly deteriorating until the patient requires total care. The patient whose premorbid personality was that of an 'outgoing' friendly individual may retain a superficial happy mien and his total lack of awareness and orientation may not be recognized.

### *Cerebral Arteriosclerosis*

These states begin between 55 and 65 years of age, in about half the cases, a history of one or more cerebrovascular accidents, a convulsion, fainting attacks, or other apoplectic phenomena will be obtained. The patient may first show a very labile and shallow affect, he is unable to watch television or read the comics without weeping, he may begin to reminisce while discussing business and become tearful. Insight may be retained in the beginning, and about 10 per cent show depressive symptoms at the onset.

A loss of memory for recent events occurs as well as a loss of efficiency with increased difficulty in performing routine tasks. The patient's personality is usually preserved.

### CHANGING ATTITUDES OF THE COMMUNITY AND THE FAMILY TOWARD THE AGED

The family's attitude toward the aged has altered during the last few decades. Homes are infrequently planned with a room for the aged parent. In the past the community did not regard too favorably the son's sending his father away to a hospital or an institution. This stigma no longer applies to the same degree in urban areas.

This change in attitude probably reflects the increased acceptance of hospitalization for all illnesses. Fifty years ago most patients were treated at home; the best room was selected, the family's routine was altered, and everyone was to some extent involved in the sickness. If hospitalization became necessary, this usually meant a turn for the worse, and the relatives or children were summoned.

Due to the marked improvement in treatment and hospital care that has occurred, when a patient goes to a hospital now he expects to return—improved. This altered thinking, this soundly based optimism, has also affected the attitudes toward the medical care of the aged.

Changes in the management of these people have resulted from differences in the structure of the family as well as differences in attitudes. Today there are fewer people available in most American homes to care for the elderly; more members of the family work or have outside obligations; finding a home which contains a maiden aunt to help out is unusual. The old maid, who formerly existed on the periphery of the family of a married sister, is practically extinct. Now the unmarried adult female is more likely to have a job or profession, her own apartment, and no room nor time to offer an aging relative.

The situation is less acute in rural areas where the change in the family structure may have been less drastic during the past few decades. Besides, in the smaller community the elderly patient may be better known; his demands are more tolerated; he has fewer

contacts with strangers and fewer hazards to face. For instance, an elderly male may be not too well oriented and he may misidentify people or enter the wrong house. If he lives in a small town he is known to the majority of his neighbors, and they feel some responsibility for him. If necessary, they may either take him home or call a member of his family.

On the other hand, the same type of patient living in a large apartment in New York City takes the elevator to the wrong floor and attempts to enter someone else's apartment. The tenant may never have seen him before, has no idea where he belongs, and does not know anyone in his family.

There are hazards in both circumstances for the patient, but the smaller community will usually tolerate such behavior longer. The degree to which the elderly are not tolerated is illustrated by the fact that in 1950 only 8 per cent of the population was over 65, but 25 per cent of the patients in state hospitals were in this age group.

### *Housing for the Aged*

It certainly seems probable that more geriatric apartments, hospitals, and nursing homes will be needed. However, unless such facilities appeal to the elderly, they will probably stand empty. The apartment units in Denmark which were designed for this group and are restricted to those over 60 have many advantages for the older individual.

In planning for the care of the elderly, the previous experiences with mental hospitals should be kept in mind. These experiences have shown the following defects in building large institutions in remote areas: they are difficult or impossible to staff sufficiently to provide adequate medical care; there is a reluctance on the part of the patient's family to "send him away" (there is an even greater reluctance on the patient's part to be sent); and the family feels a decreasing responsibility for him the longer he stays.

As the elderly increase in numbers, they will require an increasing percentage of the total time physicians have available, and the medical society will have to be directly involved in the community's search for a practical answer. The need for physicians and other trained personnel, particularly occupational therapists, may suddenly become critical in this area.

Buildings, furniture, and flooring designed particularly for the aged are necessary, but it should be emphasized that people, whether they are elderly or not, are seldom motivated significantly by anything except other interested people

### *Recommendations to the Family*

If the aged patient shows a degree of deterioration that makes him a hazard to himself or others arrangements should be made by the family for constant reliable supervision or he should be placed in a home for the aged or in a hospital. If the patient is manageable in the home and community he certainly should remain there.

The physician's final recommendation will depend on the following: the patient's wish, the degree of deterioration he has undergone, the family's attitude and interest, and the patient's financial status. If he has prepared adequately for his nonproductive years, he should be placed in the most comfortable surroundings his previous earnings will allow. Need among an elderly individual's improvident relatives is hardly an indication to deprive the patient of any care he may require.

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